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West London Medical Journal.

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Original Communications.

ON SOME EFFECTS OF A LACK OF MUSCULAR DEVELOPMENT.[1]

By W. Bruce Clarke, M.B., F.R.C.S.

Assistant-Surgeon to St. Bartholomew's Hospital; President of the Society.

It has been customary, and, I may add, I regard it as a very good custom, that your President should bring before you each year some subject, medical or surgical, as the case may be, to which his thoughts have been specially directed. It has seemed to me, especially in these athletic days, that everyone ought to be ready with an answer to the question, "What is the advantage of athletic exercise?" My predecessor in this chair took as his theme, just a year ago, the Advantages of Oxidation, and, if he will permit me to say so, the subject of which I propose to treat is a fitting corollary to it.

We are all of us familiar with the general appearance of those who lead a sedentary life, and we have learnt to attri-

[1] The Presidential address delivered before the Society on October 2, 1896.

bute such affections as lateral curvature and flat-foot to deficient muscular exercise, and to treat these conditions by muscular movement as opposed to rest after the custom of our predecessors, but it does not seem to me that we have learnt to appreciate the physical effects of lack of exercise on the organs that are placed inside our abdominal walls, and it is to these effects that I would specially wish to refer.

Undue Mobility of Abdominal Organs.

Some little time back, whilst I was looking over the notes of more than forty cases of movable kidney on which I had operated, and some notes also of cases that had not required operation, the question that I asked myself was why should an organ like the kidney alter its position, and what causes it to do so? Are the reasons that are ordinarily given adequate to explain it? And I was forced to answer these questions in the negative. I set to work to examine the other abdominal viscera, with a view to ascertain whether they also were subject to similar variations in position, and I found abundant evidence of their altered positions. The first mention of such a condition of the intestinal tract is, as far as I can ascertain, contained in a paper by Glénard on Nervous Dyspepsia, in which he describes a prolapsed condition of the intestines under the term "enteroptosis," and gives the following explanation of its production. The intestine, increased in bulk and weight by the extra weight of its sluggish contents, which are not passed onwards, finds no sufficient support on the side of the spine, owing to the relaxed condition of the flaccid ill-nourished abdominal walls. As a result it pulls on its suspensory ligaments, and causes them to stretch and elongate unduly, so that the transverse colon lies at the level of the umbilicus and the small intestine deep in the pelvic basin; and these organs readily and easily react on those which are normally situated in the pelvis, and cause them in their turn to seek refuge on the outside of the body under the name of hernial protrusions.

Unaware, apparently, of Glénard's paper, my old friend and colleague, Mr. Lockwood, made a series of measurements on dead bodies, with a view to demonstrating the prolapse of

the mesentery; and in his lectures on hernia,[1] he discusses the influence of this cause on the production of rupture. I cannot do better than quote his words on the pathology of prolapse of the mesentery. He says:—"The various affections which are associated with prolapse of the mesentery are a clue to its pathology. Given in the order of their frequency, they are prolapse of the splenic flexure of the colon, prolapse of the right kidney, prolapse of the hepatic flexure of the colon, prolapse of the left kidney. The pylorus and duodenum are at times also prolapsed, with elongation of the lesser omentum; but a mobile pylorus is such an ordinary occurrence that it hardly deserves to be enumerated amongst the other complications. The co-existence of these affections has just been adduced as an argument to prove that when acquired hernia is associated with prolapse of the mesentery, the prolapse is a cause of the hernia, and not an effect, and now it may be argued that their co-existence proves that with rare exceptions prolapse of the mesentery is not due to a local and accidental condition, but there is, except perhaps in simple prolapse, a more general deterioration in which the suspensory apparatus of the mesentery merely participates." Mr. Lockwood is equally explicit on the mode in which this prolapse of the mesentery takes place; he shows that as the root of the mesentery yields it glides down the left side of the bodies of the lower lumbar vertebræ, and allows the intestines to exercise unwonted pressure on the left hypogastric fossæ. I may add to these remarks by stating that I have seen several cases of prolapsed spleen, and one well-marked case of prolapsed liver, in which it wandered some inches, and could easily be replaced in its natural abiding place. Its dislodgment had, it is true, been caused in the first instance by an accident, but this does not alter the fact that given a sufficient force the so-called fixed organs of the abdomen are quite capable of taking excursions into their neighbour's domains, which they display but little inclination to recede from.

Of the mobility, then, of our abdominal viscera there can not be much doubt. By what mechanism are they naturally

[1] "Hunterian Lectures on the Morbid Anatomy, Pathology and Treatment of Hernia." Lewis, 1887.

maintained in position? I may anticipate somewhat by saying that in my opinion they are largely maintained in their position by the action of the abdominal muscles, and I hope I shall prove to you the truth of my statement before these remarks of mine come to a close. Of the subsidiary forces which tend to produce movement, as well as those that make for rest, we shall have more to say anon.

It is a well-known fact that the intra-abdominal pressure is, under ordinary circumstances, a positive one, that is to say, that it tends to press the abdominal contents outwards. Now, though this statement, when made as a general statement, is perfectly correct, yet the pressure is subject to great variations, and may in certain cases be negative; and what is more, the pressure varies considerably in the two sexes.

Any one who has much experience in operations on the abdominal viscera knows how easy it is to manipulate the contents of the abdomen in most women who have borne children, or who have been the subjects of large ovarian tumours, but the walls of the virgin abdomen are usually firm and tense, and present considerable difficulties when the hands of the surgeon are introduced into its interior, and this condition is more marked still in a well-developed man.

One of the most remarkable instances illustrating the extent to which intra-abdominal pressure may balk the surgeon, which I ever remember was afforded me by the following case, which I will briefly relate.

The patient in question was a big muscular man; he had devoted considerable attention to rowing, boxing, and gymnastics, and weighed over fifteen stone, though he was by no means stout, and not quite five feet ten inches in height. He had a stone in his right kidney, which it was decided to get at from the front, as the space between the last rib and the crest of the ilium behind was unusually small and unyielding. He was kept in bed a few days before the operation, moderately starved and well purged, but no sooner was the abdomen opened than the intestines began to protrude, and were only returned with considerable difficulty. It was exceedingly difficult to introduce the hand into the abdomen at all, and when it was there it was so firmly grasped owing to the positive-intra-abdominal pressure, that until the anæsthetic was pushed as far as the anæsthestist (who was well

skilled in his art) dared to push it, all attempts at manipulation proved fruitless, and at one time I thought I should be compelled to close the abdomen without even having properly manipulated the kidney. Eventually, after struggling with the viscera for more than an hour, I fixed the stone inside the abdomen, and extracted it through the muscles of the back behind, with an excellent result both immediate and remote.

Another picture of the extreme variability of intra-abdominal pressure is afforded by the case of a lady who had never borne children, which I will proceed to relate. She was about 35 years of age, and had suffered from the most intense gastric disturbance as a result of a movable kidney, so much so, that various doctors by whom she was seen were inclined to regard her trouble as primarily digestive, and to treat the movable kidney with contempt. She could take no food at all unless she maintained the recumbent position, and then only if a considerable quantity of morphine or opium was administered. On one occasion she was found on the floor, having got out of bed, and was so exhausted by vomiting that she was unable to get into bed again without assistance. Her abdominal contents, if we make a possible exception in favour of the liver, had all slipped down from their attachments, and she was suffering, in addition, from prolapse of the rectum. Regarding the kidney as the principal source of her trouble, I sutured it to the back wall of the abdomen, and she made an excellent recovery, and is now able to get about and perform her daily work without any annoyance or inconvenience. I ought to add that I performed a subsequent operation on the rectum. But perhaps the most remarkable part of this case has still to be related. At the time of the operation, with a view to making absolutely certain that no stone existed in the kidney, I had explored its interior, and so had placed a drain in the wound to carry off any urine that might escape from the interior of the kidney. To my astonishment when I was dressing the wound a few days after the operation I noticed that in her case the intra-abdominal pressure was negative, and I further discovered that the fluid which was issuing from the kidney was being sucked back again into a space apparently which surrounded the kidney. I soon found on further investigation that by placing

the patient on her right side, and by tightly bandaging the abdomen, the negative could be converted into a positive intra-abdominal pressure, but for some days the same phenomenon could be observed whenever the wound was dressed, and it did not heal completely for some time, the healing being accompanied by a certain small amount of suppuration. Such a condition, coupled with the weakness of the abdominal muscles which was so obvious in her case, seemed to call for some further treatment than that of bandaging. Though bandaging might for a time correct the results of the abdominal weakness, it could never remedy its cause. Some other means must be sought to rectify the trouble. Exercise rather than rest seemed to me to be the indication. Careful rubbing of the abdomen was under my direction daily carried out, and by degrees the walls began to gain in tone, and were soon capable of some amount of muscular contraction, instead of lying idle like the walls of a paralysed bladder. As soon as any return of muscular tone was observable the muscles were still further stimulated by exercise. Attempts were gradually made under due supervision to raise the body in bed, with great advantage both to the general health and the local conditions as well; and before long the abdominal wall, which had been before lax and flaccid, became firm, and even gave evidence of muscular development. So much was this the case that by the time the patient was well enough to walk about the abdominal wall had assumed a healthy appearance, showed no signs whatever of flaccidity or bulging, and was capable of exercising a due and proper pressure on its contents; and the bowels, which before were always torpid and sluggish, acted regularly and without difficulty, and have done so ever since.

I have dwelt with some length on this case because it was under my observation for a very considerable time, and because it illustrates so well how important a part our muscles play in the daily round of our existence and the penalties they exact from us if their health is impaired either by accident or disease.

Since my attention was first directed so forcibly to the value of muscles as an adjunct to surgical treatment I have often had occasion to call in their timely aid, and I have realised more clearly why it is that a sinus which has perhaps resisted

all attempts to induce it to heal with the patient in a recumbent position and the surrounding parts rigidly at rest, soon ceases to exist when subjected to the influence of moderate movement, which in reality keeps its sides in far closer apposition than the most perfectly arranged bandage fixed by the deftest fingers can effect.

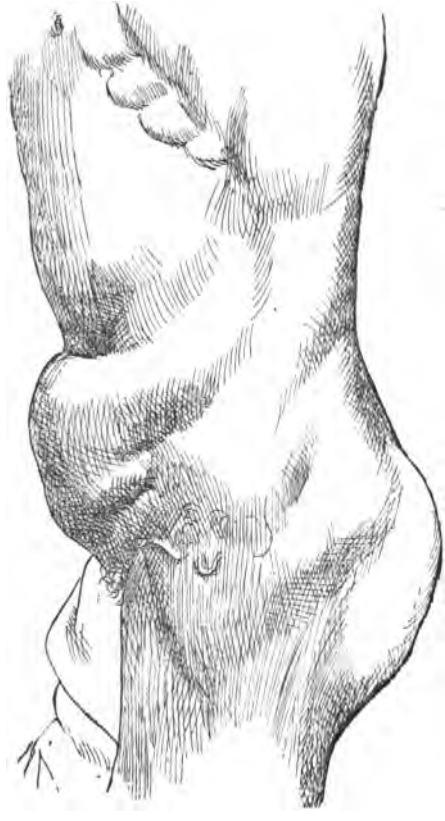
The Influence of Occupation.

The influence of occupation on the abdominal muscles is very markedly seen in the case of certain trades and employments. If we look at the abdomen of a fisherman we shall see how flat and hard it remains in most cases even up to advanced age, and this I believe is mainly due to the effect of rope-hauling and pulling, which entails such powerful contraction of all the muscles of the body, and more especially of those of the abdomen, thus ensuring their being preserved in a constant state of healthy tone. A friend of mine who is fond of yachting, and who is somewhat inclined to a little increase of abdominal girth, tells me (to use his own expression) that nothing takes his stomach down so quickly as a turn at the ropes of his yacht. It is important to remember that the *orbis veteribus notus*, as the protuberant belly of advanced and middle life has been somewhat wittily described, depends quite as much, in many cases, on the weakness of the abdominal muscles as it does on the deposit of fat on the omentum and mesenteries. Mr. Lockwood[1] has described this condition as diagnostic of prolapse of the mesentery, and so in the better-marked forms it undoubtedly is, but in its earlier state and less marked forms it is merely indicative of an incipient weakness, and can be easily and permanently cured by abdominal exercise. Indeed, I do not know any variety of this condition, however severe, which is not capable of gaining considerable benefit if subjected to such exercises as are suitable for the strengthening of weakened muscles.

It is most important that this peculiar condition of the abdomen should be clearly borne in mind, and once seen in a typical state it can never fail to be recognised on a second

[1] *Loc. cit.*

occasion. I am indebted to my old friend and colleague, Mr. Lockwood, for liberty to reproduce his admirable plate of this condition. Malgaigne, to whose observations Mr. Lockwood refers, has described the protuberant abdomen in the following terms: There is a bulging in the middle line occupying the situation of the recti muscles, and two lateral



bulges corresponding with the obliques, which seemed to have formed a shallow pocket on either side just above Poupart's ligament, in which the intestines lie ready to find their way into the inguinal canal when opportunity offers. But there is a further peculiarity to which Mr. Lockwood

draws attention, which is well illustrated in the plate on preceding page. It consists of a sinking in of the upper part of the abdomen, and a projection of the lower. I have seen this condition well exemplified in the abdomen of a tailor or a shoemaker, who often work laboriously for long hours in a half sitting, half stooping position, so that their abdominal muscles scarcely get a chance of exercise.

Now, it may reasonably be asked what further evidence there is of any connection existing between a weak or bulging abdomen and prolapse of the viscera. Let us consider each of these two conditions separately. By a weak abdomen I am of course merely referring to one in which the muscles are thin and attenuated, and the individual lacking in general muscular development, and usually thin and deficient in general stamina. It is amongst such that the cases of movable kidney that occur early in life are to be found. Indeed, I would go further and say that I have never come across a single instance of movable kidney occurring at this period of life in a well-developed muscular person, unless some severe injury was the exciting cause. Mere weakness is not sufficient of itself to produce a movable kidney, but it predisposes to such a condition. Viscera which are subjected to the pressure of healthy abdominal muscles which at the least approach of danger instinctively contract to protect them are rarely displaced.

Bulging abdomen, meaning by that term the peculiar deformity to which I have just referred, is rarely seen under 35 years of age, and certainly never occurs in a well-marked form until after 40; and it is, as Mr. Lockwood has shown, very characteristic of prolapse of the mesentery, and its special contour is, it would seem, largely dependent on the pressure exerted by the prolapsed intestines on the abdominal walls. The spleen and the pancreas participate in the movements of the intestines and slip down with them. The liver, except as a result of severe injury, is too firmly fixed to shift from its position. What happens to the kidneys? That they participate in this downward movement in many instances I am sure, from a personal examination of many bodies; that they do so in all is at present unproved. In proof of this downward movement may be cited the promptings of one's surgical instincts, whatever they may be worth,

which teach one almost automatically to look for the hilum of the kidney somewhat nearer the crest of the ilium in an old person than in a young one.

Prolapse and Hypermobility.

But it is necessary to draw a distinction between mere prolapse and hypermobility; either may exist quite independently of the other, but both alike are initiated by a lack of supporting pressure by the abdominal walls. To enter into and discuss the numerous exciting causes which either separately or in combination contribute to the production of a movable kidney, would be impossible within the limits, at any rate of your patience. My object is rather to point out how such conditions of the various viscera take their origin, and to insist on the importance of recognising their earlier stages, and of treating them by such appropriate means as may prevent the necessity for surgical operation later on.

Now, there is one symptom which is always present to a greater or less extent in all cases of visceral ptosis, and that is weariness and dragging pain. Mr. Treves, in an excellent account[1] which he has given of a case of enteroptosis, for which he opened the abdomen, describes it in the following terms: "There is a pain in the back, and a continued sense of weariness. Gastric symptoms are prominent; the most conspicuous are a sense of burning in the epigastric region, vomiting, pain, loss of appetite, distress after food, and more or less dyspepsia." Again: "One important feature remains to be noticed. The symptoms are more or less relieved by pressing upon the lower parts of the abdomen with the two hands, or by the wearing of a supporting belt. Many patients are unable to move about until they have adjusted their supports or bands. The physical signs need not be dwelt upon. The kidneys are found to be movable, the liver and the stomach are prolapsed, and return more or less to their normal position when the patient is recumbent."

When one is face to face with such a condition of things as is here depicted, there can be no doubt of the need for some abdominal operation: the only question is, which organ must be tackled first? My object to-night, as I have just said, is

[1] *British Medical Journal*, 1896, vol. i. p. 1.

to indicate how to prevent ptosis rather than to describe, as I have already done on more than one occasion,[1] how to relieve it. If the facts which I have brought before you to-night are correct—and I do not feel any doubt that they are amply proved—muscular weakness of the abdomen is but the first step in visceral ptosis, and without muscular weakness this condition cannot exist. The dragging pain, weariness, and *malaise* which so many individuals complain of, especially those who are not strong, should be regarded as a symptom which can be treated, and treated with success, and of this I now propose to adduce some instances.

A young girl, aged 16, became a patient of mine about eighteen months ago. She had never been robust in health, and had recently suffered from an attack of influenza, which had left her very weak. She came under my care in consequence of some severe pain in the back, the nature of which was very obscure. Though she was nearly 5ft. 5in. in height she did not weigh 6 stone, and was said to have lost flesh recently. She had been under the care of a physician in the country, who had pronounced her lungs sound but had advised a change abroad, at the same time directing that great care should be taken not to overdo exercise. She had been in Switzerland, but her appetite was poor and fitful, and she had derived no benefit from her visit. When I first saw her she could not walk for more than ten minutes at a time without weariness and dragging in the back and loins, and her monthly periods were very scanty. I made a careful examination of her back and body generally, with a view to discovering some cause for her pain. She was so thin and emaciated that there was no difficulty in doing this. All that I could discover was muscular wasting. Her abdominal walls were so thin that the various organs could be mapped out with the fingers with facility, and the spleen and the kidneys handled almost as easily as if the walls of the abdomen had been removed. There was an incipient lateral curvature.

I regarded her case as one entirely of muscular weakness, and her pains and dragging sensations and weariness as the

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[1] "Acute Renal Dislocation," *Med. Chir. Trans.*, vol. lxxvi., 1894. "Remarks on a Series of Thirty Cases of Movable Kidney treated by Operation, with their Results," *British Medical Journal*, March 16, 1895.

result of the lack of muscular support to the viscera, and I told her friends that I believed after such a course of exercise as could easily be carried out in England she would recover her strength. It was at first difficult to persuade her that she was capable of doing anything; and when I prophesied that in a few months she would be able to row with her brothers I am sure I was not regarded as a man of truth; but my prophecy was fully justified, and to-day she is capable of hours of continuous exertion, and is in good hard condition, weighing upwards of 10 stone.

The plan which I adopted was as follows: I ordered, to start with, five minutes' exercise for certain muscles, beginning with those of the back and abdomen, which was carried out by her maid; the back and abdomen were gently rubbed with a stimulating liniment, to impart a sensation of warmth, and then she was assisted to get up from the recumbent position and return to it again without the aid of her arms. By the end of a fortnight she could do this alone, at least once an hour for twelve hours. Her appetite improved, and she was anxious to try to walk. I had refused to allow walking at first, because if my interpretation of the symptoms was correct, her viscera ought not to be dragged on without support. As soon as she found what rapid progress she was making she entered very fully into the scheme of her treatment, and proved herself very ingenious in suggesting little exercises. At the end of six weeks she desired to try to row, and was permitted to do so. Shortly after this a rope and pulley was rigged up for her, and by altering the weights she had to raise, and working sometimes one hand, sometimes both, the muscles of her trunk and limbs increased rapidly in firmness, and her appetite improved amazingly, and with the growth of her muscles her lateral curvature disappeared, and all weariness about the back and loins came to an end.

Since that time I have on a good many occasions prescribed analogous movements in consequence of pains about the abdomen and back, and always with considerable advantage, though never perhaps with so striking a result as in the case just related.

I daresay I may be told that there is nothing new in my suggestion. It is only our old friend, movement cure, in a different dress, and I grant that there is some truth in the

contention, but the point on which I am specially insisting is that our viscera, our blood vessels, our spinal cord, and our bones need healthy muscles to keep them in their proper position and condition, and especially is this the case with intra-abdominal viscera. If this truth were better recognised than it is we should not be ordering as many belts and supports as we do, but we should rely on the means of support which Nature has given us, and strengthen them if they need it by healthy exercise, and not by steel bands.

Once more, gentlemen, let me thank you for placing me in this chair, and for listening with so much attention to this, I am afraid, somewhat too lengthy address.

INTRA-PERITONEAL HÆMORRHAGE IN CONNECTION WITH TUBAL PREGNANCY.

By J. A. Mansell Moullin, M.B., M.R.C.P.Lond.
Physician for Diseases of Women, West London Hospital.

The very great interest which this subject has for all practitioners must be my excuse for bringing before you the following notes.

Intra-peritoneal hæmorrhage resulting from rupture of the Fallopian tube can hardly fail to be recognised by the suddenness and severity of the symptoms which attend it. It is not, however, so generally known that rupture of the tube is not necessary for intra-peritoneal hæmorrhage, but that the presence of an ovum in the tube at a very early period excites a bleeding from the fimbriated extremity, and the formation of hæmatocele.

The blood is not, as a rule, poured out so rapidly as when the tube is torn. The symptoms are consequently not so marked; the shock is not so great, but in other respects the symptoms are identical.

Such cases are of frequent occurrence. Arrest of the impregnated ovum in the tube is a much more common event than is generally supposed, and although it is not the only

cause of hæmatocele, it certainly is so in the very great majority of cases.

Now when an impregnated ovum becomes arrested in its course through the Fallopian tube, it must follow either that (1) the ovum perishes or aborts; (2) it continues to survive with eventual rupture of the tube; or (3) it survives without causing rupture of the tube. The latter alternative is one which certainly does occasionally happen, the pregnancy going on to full time. The ovum in this case is probably arrested quite at the fimbriated extremity, and either escapes from the tube altogether, or distends the abdominal ostium over its sac. It is sufficient, however, to mention the fact, and at the present time it need not further detain our consideration.

In the great majority of cases the ovum undoubtedly perishes at a very early period of its existence. To this condition the term "tubal abortion" has been given by Mr. Bland Sutton. The term has obvious merits, though it has been objected to on the ground that the ovum is not expelled but retained in the tube. The term signifies merely that the ovum fails to arrive at maturity, and I can see no objection to its use.

Tubal gestation, I may remind you, has no symptom in the early stage by which it can be recognised. The first intimation that anything is amiss may be a sudden agonising pain in the lower abdomen, attended with increasing faintness and collapse. The tube has ruptured, free hæmorrhage is going on internally; the peritoneal cavity is rapidly filled with blood, and the patient's condition quickly becomes too serious to afford the chance or hope of any successful interference.

Fortunately, however, the initial symptoms, though characteristically sudden in their onset, are not always of this extreme severity. After some hours the pain becomes less; the shock and collapse are followed by reaction and probably some rise of temperature. The pain is usually attended by a hæmorrhagic vaginal discharge, which the patient supposes to be the ordinary catamenia, though the time for this may be slightly overdue. There is some distension of the abdomen, and great tenderness in the hypogastric region.

No physical signs are present at this early stage. No tumour can be discovered either by palpation or bimanual

examination. The diagnosis rests entirely upon the pain, associated with the symptoms before mentioned. Hæmorrhage, however, has been going on all the time, not from a rupture, but slowly dribbling out of the abdominal ostium of the tube into the peritoneal cavity, just in the same way as it has been escaping from the uterine ostium and through the vagina. The amount of blood effused in this way may be very considerable, and may recur at intervals, giving rise to fresh attacks of pain.

Pain is the symptom which should at once arrest the attention of the practitioner — a sudden abdominal pain, attended by vaginal hæmorrhage, occurring after a rather longer interval than usual since the preceding catamenia.

Such cases, I am certain, often escape recognition. The attack is pronounced to be a pelvic inflammation of some sort, and as the patient, after weeks in bed and a protracted convalescence, is able to get about again, the medical man is satisfied, and the matter perhaps forgotten, until at some later date a secondary pelvic trouble brings her again under notice.

The formation of a definite circumscribed tumour by blood effused into the peritoneal cavity has not hitherto been sufficiently recognised. Everything depends upon the rapidity with which the blood is poured out. In the case of a sudden severe hæmorrhage, the blood is diffused throughout the peritoneal cavity, but it is otherwise with the slow dripping which takes place from the fimbriated end of the tube which contains an impregnated ovum. The old teaching on this subject, that hæmorrhage into the peritoneal cavity is always diffuse, and that any well-defined and circumscribed blood tumour must be situated between the layers of the broad ligament is absolutely incorrect.

Blood slowly effused coagulates to a greater or less extent, and the presence of the coagulum excites an inflammatory action in the peritoneal surface with which it comes in contact. This results in the exudation of plastic lymph, and the surface of the peritoneum is roughened. Extensive adhesions are formed between neighbouring surfaces, and the blood clot is confined within a circumscribed cavity. Further changes take place in the blood clot itself. A formation of new tissue takes place in the outer layer, forming a capsule or cyst wall for the more fluid contents. This in places becomes intimately

adherent to the surrounding organs, and where these are absent forms a limiting membrane for the hæmatocele.

Occasionally, as Mr. Taylor of Birmingham has described, this outer layer forms a complete capsule, which is only lightly adherent to the surrounding viscera, and the hæmatocele may be enucleated and removed entire like a small ovarian cyst. The cyst wall is continuous with and surrounds the fimbriated extremity of the tube, which may be extracted from it by gentle traction. To this peculiar condition has been given the name "solitary" or "encapsulated" hæmatocele.

The following cases very well illustrate the condition just described.

CASE 1.—J. M., aged 35, admitted into the West London Hospital November 28, 1894; had been the mother of one child. There was no history of any pelvic trouble. The catamenia had always been regular and free from pain. The last occasion was on September 20. The period due in October had been missed, and about a fortnight later the patient was suddenly seized one evening when getting into bed with the most violent pain in the lower part of the abdomen. For a month the pain recurred at intervals, the attacks lasting for several hours. The abdomen was soft and flaccid. On bimanual examination a rounded tumour could be felt behind the uterus. The tenderness was very great, and the examination seemed to start the pain afresh. Tubal gestation was diagnosed. Mr. Eccles kindly gave me his assistance at the operation. An ovoid mass, the size of a large orange, was removed from the pelvis. On opening the tumour it was found to consist almost entirely of semi-fluid blood clots; a portion near the tube appeared to be of greater consistency, and on opening this a sac was found with an embryo of about the third week, attached to the wall by a minute thread. The tumour was universally agglutinated to the neighbouring structures, but was easily enucleated without rupture. There was no trace of free hæmorrhage into the general peritoneal cavity. This case presents a very typical example of the encapsulated hæmatocele described by Mr. Taylor.

CASE 2.—S. C., aged 26, admitted February 6, 1896; was sent to me by Dr. Disney Roe of Bow, who recognised the nature of the case and sent me a note with particulars. She

had had a child two years previously. No period had been missed for the last six months; menorrhagia had been present for eight weeks. Five weeks before admission she had been taken with a sudden pain in the right side of the lower abdomen and vomiting, which, with the pain, continued for fourteen days. She had been confined to bed since the pain commenced.

On vaginal examination the uterus was found to be slightly enlarged and tender on pressure; no fixation and no tumour. Ten days later she had paroxysmal pain about every fifteen minutes, lasting some hours. This was attended with severe loss and some evidence of membrane.

She was again examined, and a softish, ill-defined swelling was found on the right side of the uterus. This may have escaped notice at the previous examination. It proved to be a small hæmatocele, closely applied to the fimbriated extremity of the tube, and circumscribed by the omentum, intestines and broad ligament. The tube and ovary were removed intact. No rupture had taken place, but a small ovum the size of a walnut was found in the distal portion of the tube. The left ovary was cystic and was removed at the same time.

Case 3.—L. E. K., aged 24, admitted into the Hospital for Women, January 20, 1896. One child eleven months previously. In this case also the doctor who saw her in the first instance recognised the probability of tubal pregnancy. On September 25 she was seized with abdominal pain. The last period had been eight weeks previously. Vaginal hæmorrhage occurred the following week, and a few days later, on examination, a small, tender, movable swelling was found behind the uterus. By slow degrees this swelling increased and eventually surrounded and fixed the uterus, which was considerably displaced downwards. The tumour could also be felt through the abdominal walls, especially on the right side. The temperature was slightly raised. The dark bloody discharge persisted for seven or eight weeks, but was slight in quantity after the first week or two. On January 16, 1896, the uterus was in fair position; behind it was a swelling nearly filling Douglas' pouch, and closely attached to the uterus and in that way fixing it.

She remained in bed for two months, and the tumour

gradually diminished in size, until all that remained was a small movable tumour behind the uterus. At the operation this proved to be a small hæmatocele between the end of the tube and the ovary, and was removed entire. On cutting into the tube, which was much thickened, there was found at one spot a hardish nodule—the remains of the ovum. The opposite ovary contained a more than usually well-marked corpus luteum of pregnancy.

CASE 4.—A. N., aged 26, admitted into the Hospital for Women, March 4, 1896. Had had five children, the last born February 23, 1895. In the following June she was suddenly seized with pain and vaginal loss, which continued on and off for two months. In February she came to me complaining that for the last six months the catamenia occurred every fourteen days, with profuse loss for five days. She had pain in the left side, aggravated by exertion, and sometimes intense on defæcation. I found a tender swelling behind the uterus and to the left side. At the operation (March 23) this swelling proved to be the left ovary and tube, bound down by adhesion; behind them a small cavity containing the remains of old blood clots. The mucous membrane of the tube was much thickened, but no ovum was discovered. Right ovary and tube appeared to be healthy, and were returned. The hæmatocele had probably been formed when the patient was seized with pain and loss in the preceding June, and affords an illustration of what often happens when no operation is undertaken at the time, but the patient allowed to recover unaided. The hæmatocele had almost disappeared, but the ovary and tube were bound down by adhesions, and so tender and painful that their removal was necessary. The condition was, of course, not recognised before the operation.

CASE 5.—H. S., aged 40, admitted into the West London Hospital, July 29, 1896. Has five children, the youngest three years old. No previous illness of any kind, and the catamenia always regular until the preceding April. Illness then commenced with floodings, which continued on and off for ten weeks, when she came under my care. At the commencement of the illness there had been severe pain down the legs, but only a slight worrying pain in the abdomen, which persisted. I found a large and very tender swelling behind the uterus,

which was fixed. After resting in bed for a month the swelling much diminished, but there remained an exceedingly tender rounded tumour about the size of an egg behind the uterus, and closely connected with it. I believed it to be a distended tube.

On August 4, assisted by Mr. Knight (then house physician), I opened the abdomen and removed the appendages on the right side. The tumour proved to be an encapsulated hæmatocele attached to the fimbriæ of the tube. The latter, about an inch from its extremity, was thickened, and on laying it open some *débris* of clot was found adherent to the mucous membrane.

Certain practical considerations at once occur to us from the history of these cases:—

(1) Is the sudden attack of pain which constitutes the initial symptom due to the effusion of blood into the peritoneal cavity? When rupture takes place the pain may be readily accounted for, but it is not so obvious when there has been no rupture. At the same time either as cause or effect the ovum perishes.

(2) What are the physical signs by which an intra-peritoneal hæmatocele forming a pelvic tumour can be distinguished from a hæmorrhage into the broad ligament? Any tumour or collection of fluid in the broad ligament has the result of fixing the uterus, at the same time displacing it downwards and to the opposite side of the pelvis. The peritoneal layer cannot be stripped off the posterior surface of the uterus. It follows, therefore, that if the tumour be found behind the uterus, or extending all round it, it is unlikely to be within the broad ligament.

(3) It is more difficult than might be imagined, even after opening the abdomen, to determine whether the hæmorrhage be within the broad ligament or behind it. On opening the abdomen, it often happens the dark blood clot comes into view under a membrane which has all the appearance of a layer of lifted peritoneum. This is really only the adventitious membrane formed by the outer layer of blood clot, as previously described. On opening this, if it has not been already torn, and flushing out the clots, the hand passes into a roughened cavity which might readily be mistaken for the space between the layers of the broad ligament. In reality it is not so;

it is simply the posterior surface of the ligament roughened by the remains of blood clot and adherent shreds of lymph. A careful examination of the tube proves that no rupture has taken place, and that consequently the hæmorrhage is not within the ligament.

(4) We have now to consider briefly the subject of treatment. If internal hæmorrhage is recognised, most unquestionably operative interference is the only remedy upon which reliance can be placed. The danger is not over when the attack of pain has subsided and the patient appears to be recovering from the shock. A recurrence may happen at any moment—indeed, is to be expected. Some discrimination must, however, be used, and the operator may have some anxious moments in deciding the course to adopt. If the hæmorrhage is profuse and the patient much collapsed, it is certain the shock of an operation will only hasten a fatal result. Nature is already doing her best to arrest the hæmorrhage. The blood pressure is reduced to a minimum, and no further loss is taking place. Allow the patient to rally if she will. In the course of a few days she may be better able to stand the operation. Local peritonitis has meanwhile taken place. The torn surfaces are swollen, the vessels plugged with clots, and an operation now will be unattended with further loss of blood.

More frequently the case comes under notice at a later period. A blood tumour is found filling the pelvis. The patient is already making some progress towards recovery, and the question arises whether to leave the repair to nature or open the abdomen. When a hæmorrhagic tumour of any size is present, I am sure the better course is to open up and flush out the clots. Absorption sometimes takes place with great rapidity, but on the other hand an amount of peritonitis is sometimes excited which necessitates interference before long. Encapsulation of the hæmatocele probably greatly retards absorption. In most cases expectant treatment signifies a protracted convalescence, and the great probability of an operation being required eventually to relieve some chronic or secondary complication which may arise, as in my fourth and fifth cases above narrated.

A CASE OF FÆCAL FISTULA DUE TO SELF-MUTILATION, OCCURRING TWICE IN THE SAME PATIENT; TREATED ON EACH OCCASION BY ABDOMINAL SECTION AND ENTERECTOMY (1) BY WIDENHAM MAUNSELL'S OPERATION, AND (2) BY MAYO ROBSON'S BOBBIN. RECOVERY. REMARKS ON THE TREATMENT OF PARIETAL FÆCAL FISTULA.

By Fred. Bowreman Jessett, F.R.C.S.

Surgeon to the Cancer Hospital, Brompton, and the Gordon Hospital for Fistula, &c.

I am indebted to Mr. Pounds of Derby, Dr. Macphail of Derby Borough Asylum, Mr. Christopher Martin and Dr. Malins, Birmingham, and Dr. Faussett, Tamworth, for the history of the patient prior to her admission into the hospital. For the notes of the case during her sojourn in the hospital I have to thank Mr. A. White, my house surgeon.

The patient, an unmarried woman, aged 23, was admitted into the hospital under my care on December 9, 1895, suffering from a fistulous opening in the abdominal wall communicating with the intestinal canal. There was nothing important in her family history, and I will not weary you with the details of her previous history; suffice to say, in 1891 she was under Dr. Pounds' care suffering from profuse metrorrhagia, repeatedly threatening a fatal termination. Dr. Pounds found on examination a tumour the size of a small orange fixed to the bottom of Douglas' pouch. He performed cœliotomy, and removed her tubes and ovaries, both of which were diseased. She did very well for ten days, when she developed symptoms of gastric ulcer, vomiting so incessantly that latterly nothing was given by the mouth. This lasted for ten weeks, when Dr. Pounds, suspecting a neurosis, either central or reflex, and the possibility of an adhesion to one of the ovarian pedicles, re-opened the abdomen and found a loop of intestine tightly pulled down and adherent to the left ovarian stump; this was released, and the patient made a good recovery, all vomiting ceasing, and she left the hospital cured.

She next was heard of stealing and pawning everything

she could lay her hands on to purchase opium, and she was drifting into a state of dementia, for which she was sent into the Borough Asylum, where she remained from January 18 to April 28. She then went to her home at Tamworth. The patient next came under the care of Mr. Christopher Martin suffering from a vesico-vaginal fistula, or rather the urethra was slit up from the meatus to within an inch of the os uteri. Mr. Martin operated on her for this and considerably improved her condition.

Next we hear of her at the Jaffray Hospital under Dr. Malins, suffering from some pelvic trouble, for which her abdomen was again opened, but nothing more than some chronic peritonitis found. During her stay in this hospital she got hold of some opium pills and was very ill in consequence. She was discharged and sent back to Dr. Faussett, of Tamworth, as an inmate of the Union Infirmary. Between the time she left the Jaffray Hospital and being admitted into Tamworth Infirmary a fæcal fistula formed in the scar on the abdomen, which was supposed to have been self-inflicted. As the fistula showed no signs of closure Dr. Faussett sent her on to me.

The condition of the patient when admitted under my care was as follows:—She was fairly well nourished and well developed, and was intelligent. She was highly neurotic, sly, and deceitful. This had been discovered by the nurses in charge of her, who had reported many acts of deceit. She took a great interest in her condition, on which she talked readily. Except for fistulæ, vaginal and abdominal, there was no disease. Her thoracic and abdominal viscera were normal. She passed urine freely and without pain. There was a slight discharge of urine at times from the vaginal fistula. She never had a natural evacuation of the bowels unless after an enema, and then not always. Her appetite was fair. The urine was normal. In the middle line, midway between the umbilicus and pubes, was an opening barely admitting the little finger, through which flatus and undigested food, together with a thin, watery fluid, escaped from time to time. The skin around was puckered and excoriated and was very tender. The whole abdomen was tumid but not markedly tender. Two and a half pints of soapy water were injected into the rectum, some of which appeared at the abdominal

opening. The fluid which escaped from the fistula consisted of a clear, faintly alkaline liquid, not viscid, containing portions of undigested food. On December 10 a draught of bismuth and soda was ordered for vomiting and pain after food. As the patient was in constant pain from the excoriated surface and did not sleep, $\frac{1}{4}$-grain morphine suppository was ordered every four hours and the skin was smeared over with iodoform ointment. The suppositories were omitted when she seemed free from pain. On the 12th, at 5.30 a.m., the house surgeon was called to see the patient, as the nurse could not rouse her and she "seemed queer." She was found to be cold, almost pulseless, and in a state of profound collapse. The pupils were contracted and the breathing was infrequent, irregular, and sighing. She was to all intents and purposes *in articulo mortis*. The nurse stated that the patient had not had a suppository since 10 p.m., and that she had had only three in the previous twenty-four hours. She could not be roused nor could she swallow. Morphia poisoning was diagnosed. Hot bottles were placed round her, and she was wrapped in hot blankets. Strychnia muriate ($\frac{1}{100}$ gr. in 20 minims of brandy) was given. Two ounces of beef-tea and half an ounce of brandy were given by the rectum. The pulse improved considerably from being almost imperceptible, and the patient could be roused, but she soon sank again into her previous condition. An enema of hot coffee was given and she was kept warm. This resulted in a slight improvement. Half a pint of hot coffee and half an ounce of brandy were given every two hours, and beef-tea by the mouth when possible. At 10 a.m. the condition improved; the pulse was better, but the patient was still unconscious. At 12 noon a relapse occurred; strychnia ($\frac{1}{100}$ gr.) was given and the coffee was continued. At 4 p.m. there was much improvement and the pulse and breathing were much stronger. She could swallow and could be roused. She was very sick. Five minims of tinctura nucis vomicæ and ten minims each of tinctura belladonnæ and spiritus ætheris sulphurici were ordered. The urine had been passed under her; nothing passed by the fistula. The urine reduced Fehling's solution to thick green precipitate. There was no result with phenyl hydrazin hydrochlorate beyond a brownish precipitate; this was probably due to glycuronic acid after morphia. After this the patient improved rapidly. The

reducing power of the urine gradually disappeared and was absent on the third day after the onset of this condition of collapse. On the 17th nitrous oxide gas and ether were administered, $\frac{1}{100}$ gr. of strychnia having been previously injected under the skin. Mr. Cotterell assisted at the operation. In the early morning the patient had had half an ounce of castor oil, at 11 a.m. one ounce of brandy and four ounces of beef-tea by the mouth, and at 1 p.m. two ounces of brandy and three ounces of beef-tea (peptonised) by the rectum. The fistula was enlarged and a portion of the small intestine was found to be adherent to the scar of the previous section. This was excised for about four inches, and the intestine was united by end-to-end anastomosis by Widenham Maunsell's method. The peritoneum was cleansed and the wound sewn up with silkworm gut. The patient stood the operation well. On the following day, after a fair night, although some vomiting occurred, she was ordered two ounces of milk every two hours with Benger's food. Half an ounce of brandy was to be given every four hours. She complained of flatulence and some pain. On the 23rd, the bowels having been opened *per vias naturales* every day since the 19th, she had boiled fish and jelly for her meal. There was no sickness or pain after. The sutures were removed on the fourteenth day, the wound having healed without a symptom. The excoriation healed under cimolite dusting powder. After this the patient went on quite well, being detained for a sore place on the hip due to a slight burn from a hot-water bottle which occurred on the occasion of the morphia poisoning. On Jan. 29 she was told to make arrangements to go home, the wound being quite sound. At 1 p.m. on that night the house-surgeon was called to see the patient, who was said to be bleeding. He found a clean incision about one and a half inch long and half an inch deep in the cicatrix of the abdominal wound. It was drawn together with strapping. The patient was watched carefully and a blood-stained handkerchief was found under her pillow. The wound became deeper and deeper, and finally on Feb. 1, a fæcal fistula again established itself. On Feb. 3 she was in much the same condition as on admission. There was a well-marked intestinal fistula. The skin was very red, excoriated, and tender. The abdomen was tumid and tender. She was very hysterical, lachrymose, and depressed. She

denied having touched the wound when taxed with doing so. She continued to be in much the same condition up till Feb. 25, when I performed another operation; the fistula was enlarged and four and a half inches of gut were excised and united end to end by Mayo Robson's bobbin. She stood the operation quite well. The portion of bowel removed was on examination found to be quite distinct from that removed at the first operation. On the 26th she had a restless night and was very sick. Flatulence and abdominal pain occurred. Three ounces of beef-tea and half an ounce of brandy were given every four hours as an enema. A nutrient suppository was also administered every four hours. Barley water in small quantities was given from time to time. On the 27th the patient was better. There was no sickness and the pain was less. One drachm of Brand's Essence was given every three hours by the mouth, thin Benger's food every hour, and a nutrient suppository every four hours. On the 28th the bowels were well opened. The same diet was continued, with the addition of one ounce of beef-tea every two hours. On March 3 the diet was the same. No pain was experienced. There had been no rise of temperature since the operation. On the 4th she was improving steadily. There was no pain and the wound was quite healthy. She was ordered to have fish. On the 7th she was on ordinary light diet. Her condition was quite good and the wound was healthy. The bowels were opened freely daily. From this date till her discharge on March 30 she made a steady recovery without any complication. Her dressings were sewn on and the wound and abdomen were covered over with collodion-wool and rubber plaster. The whole was covered by a stout linen jacket and drawers which were sewn on so that she could not possibly reach the wound. She was discharged from the hospital, and placed under the care of her friends quite cured and in good bodily health.

In these days of progressive surgery, especially the surgery of the intestines, I ventured to think that this case might prove of interest to your Society. It is not many years ago when a case of fæcal fistula was looked upon as incurable. Dupuytren was the first surgeon, I believe, who recognised the true condition of the intestine in these cases, and introduced with some success the clamp, which now bears his

name, which he applied with the object of breaking down the spur of mucous membrane which is always found in cases of fæcal fistula, and thereby restoring the continuity of the canal, and enabling him to close the external opening by paring the edges and uniting them with a few stitches. Numerous improvements on the clamp were devised by Roux, Reybaud, Heine, Blasius, and others, but the results of the operation were not satisfactory. Mr. A. Barker suggested and published a case in which he had practised a modification of Dupuytren's method. He suggested that the spur of the mesentery should be destroyed by pressure forceps applied, that the intestine should be lined with a thin sheet of india-rubber, one and a-half inches long and five-eighths wide, which is to be fastened *in situ* by silver wire sutures passing quite through the abdominal parietes. He then pared the edges of the fistula and stitched them together; when they were united he withdrew the silver wire sutures, and the piece of rubber which lined the bowel was passed *per rectum;* or, as in the case he published, he withdrew the rubber at the end of a week through the wound, and let it close by granulation. No doubt in cases of very small fistulæ, if they do not close of themselves in a short time, by paring the edges of the fistula and introducing two or three deep sutures they will readily heal.

I think at the present day the consensus of opinion is in favour of opening the abdomen and excising the damaged piece of intestine, and restoring the continuity of the canal either by end-to-end anastomosis or by lateral apposition.

For this purpose numerous contrivances have been suggested by surgeons who have taken an interest in this work. To Senn, of Chicago, I think belongs the credit of first giving a fillip to intestinal surgery; and by repeating his experiments in this country and publishing the results, as well as by publishing a few cases of successful operation, I think I may claim to have been the pioneer of intestinal surgery in this country. Since then, however, numerous improvements have been introduced—Murphy's buttons, Mayo Robson and Allingham's bobbins, Paul's and my own tubes, Widenham Maunsell, Bishop and Halstead's operations; and now I think there are some who discard all these, and prefer uniting the divided ends of the intestine by simple suture.

Of Murphy's button I have had no personal experience, as, although a most ingenious contrivance, I should always oppose the introduction of a foreign body such as the button into the intestines, and I believe very few surgeons now adopt its use.

Of Robson and Allingham's bobbins, I think they are admirable, and by their adoption much time may be saved, and the results, as shown by the case I have related to you, as well as by published cases, in which the bobbin has been used, are such as, in my opinion, to place it as quite the best method yet introduced.

Widenham Maunsell's operation, likewise, is admirable, and gives excellent results. His operation is practically the same as that suggested by myself, and which I had carried out in the experiment I published some years ago for the treatment of certain forms of intussusception.

In those cases in which it is deemed advisable to adopt lateral apposition I think Senn's plates are good, but the bobbin can also be employed in these cases, or if the surgeon elect to use no supports, then I consider Halsted's operation by far the best.

One word, and I have finished in reference to the case, notes of which I have read to you. When the patient was first admitted under my care we knew nothing of her previous history so far as the unsoundness of mind was concerned, and it was only when she opened up the wound and established the second fæcal fistula that it was suspected that she had inflicted the injury upon herself. There is one thought which cannot escape notice in this very remarkable case, and that is, notwithstanding the number of operations she had undergone, and the injuries she had presumably inflicted upon herself, she never had any dangerous inflammatory symptoms, and she convalesced in a most marvellous manner from all the operations. Is it a fact, I should be glad to learn, that persons of unsound mind do recover from severe operations more readily than people of sound mind? And, further, do people who have established an opium habit stand operative procedure better than others? Dr. Collings, of Carlisle, has drawn my attention to the fact that wounds do seem to heal better in persons of unsound mind.

There are many surgeons belonging to this Society who have paid special attention to intestinal surgery, and I think

it will be of great interest to the Society and profit to the profession at large, if they will give us the benefit of their experience and the results of their operations.

ON THE DIFFERENT FORMS OF RHEUMATISM.[1]

By Seymour Taylor, M.D., M.R.C.P.

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Rheumatism is a disease of many aspects. It is not a disease confined to youth, and "those with green knees," nor does it necessarily "prevail in autumn," as one of our older classical authors appears to have imagined. But it is a disease which presents itself in guises quite as numerous as does gout. For this reason the nomenclature is at once either easy and comprehensive, or it is difficult and diffuse.

Rheumatism does not necessarily show itself as an osteo-arthritis, although to most minds the term conveys the idea of joint trouble. It were better to say that an osteo-arthritis may be rheumatic, although rheumatism is by no means always osteo-arthritic; since clinical evidence is in favour of the view that rheumatism may show itself in several distinct forms, two or more of which may appear in the same individual. Further, of those varieties, some, if not all, may appear as well in the form of acute as of chronic disease; whilst again the same type of attack in the individual may vary, at times being an acute manifestation, at others a chronic ailment. In these respects it somewhat resembles pyæmia, which may be acute, or may be chronic; which may on the one hand spend its fury in the destruction of a joint, or, on the other hand, terminate in a fatal visceral lesion.

These clinical facts being granted, it occurs to us to speak of rheumatism as being manifest in the following forms, one or more of which may appear in the same individual, viz.:—

(1) Osteo-arthritic (acute, chronic, or subacute).

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[1] A Post-Graduate Lecture delivered at the Hospital, December, 1896.

(2) Serous (endocardial, pericardial, pleuritic).
(3) Tonsillitic.
(4) Choreic.
(5) Nodular.
(6) Cutaneous (erythema nodosum, urticaria).
(7) Ocular (iritis, glaucoma).
(8) Muscular.

The above list might be extended, but it includes the varieties which are most frequently met with. Some of these distinctive types I shall show you to-day, so that we can warn ourselves against the error of thinking that rheumatism appears only in the garb as described by the older writers; for if our view were so limited we should fail to recognise many cases, and should consequently often fail in our treatment.

Why does rheumatism present so many aspects? I contend that for the production of a good crop as much, if not more, depends on the suitability and the fertility of the soil as on the vigour of the seed. We see adjoining fields planted with identical seed, one of which is prolific at harvest, the other with a scanty crop. We see two children of the same family stricken with the same fever poison. One perishes from the fever; in the other, the poison produces little beyond a few days of malaise.

Similarly, the individual is favourable or unfavourable to the acquisition of rheumatism, for it is impossible to always avert exposure to predisposing and exciting causes. But the diathesis of the individual will in the one case produce a joint lesion, or a valve inflammation, or a skin affection, or a neurosis, as the case may be.

Some years ago, a remarkable paper by Hutchinson[1] opened out a great field for clinical research. He contends, and in the main I am disposed to think that he is correct, that there exists through long descent a hereditary diathesis, which makes an individual prone to rheumatism or to gout, or perhaps to both. That is to say, granted this diathesis, a man may travel down the road of life for a certain number of years till he arrives at a sort of pathological junction, where he may be either switched on to the line of rheumatism

[1] International Medical Congress, London, 1881.

or on to that of gout—nay, indeed, that he may travel both routes and ultimately acquire a hybrid disease, commonly known as rheumatic gout. And, moreover, that the determining "pointers" which shall guide the sufferer to gout are imperfect digestion and disease of the kidneys; whilst the guiding factor towards rheumatism is exposure to cold and wet, and to this I would also add the septic poisons of certain decomposing matters.

But confining our attention to rheumatism there is, I contend, a more minute sifting of diathesis, a more complex distribution of effects. The patient once being on the rheumatic line, he may have a series of ailments, all apparently distinct from each other; and the particular form which rheumatism takes will depend on the condition of his blood, the integrity of his nervous system, the condition of his throat, or the strain which has been put on his joints, and so on. A stone may, and has, diverted the flow of a river into a channel altogether different from Nature's intent; and similarly, some local weakness of constitution of the individual may determine the form which rheumatism shall take.

(1) The commonest type of acute rheumatism is that which produces a severe synovitis of the larger joints, and which is attended by high fever, great prostration, and marked diaphoresis. The subjects of this form are, as I have pointed out elsewhere, very often young men, of flabby muscular fibre, inclined to obesity from the consumption of much malt liquor, and they are not infrequently myopic.

Death seldom occurs during the initial attack, but from subsequent cardiac affection, or from a second invasion, during which a previously enfeebled heart is overwhelmed.

(2) The serous type of rheumatism may exist without joint trouble; and I am bound to say that we overlook this possibility. We are apt to regard endo- or peri-cardial disease as being only a sequel to rheumatic synovitis; but we shall see later on, in referring to the choreic form, that rheumatic heart disease may exist without joint lesion.

Two clinical points of extreme interest arise during an attack of this type, viz., the relative frequency of pericardial and endocardial inflammation, and severe delirium.

Statistics can easily be made to show that pericardial in-

flammation is more frequent than endocardial, and *vice versa*. But brushing all figures on one side, there remains the deep impression on my mind that endocarditis is not only the more severe affection, but unfortunately the more frequent; and I make this statement on the following grounds: (*a*) endocarditis may be overlooked in consequence of the soft character of the murmur at onset; (*b*) even when undoubtedly present the murmur is apt to be drowned by the louder and more superficial noises generated by the pericardium; (*c*) it may even exist in so mild a degree at first as to cause no murmur; but shows itself subsequently if the patient be allowed up from his bed and dismissed too soon.

Delirium has always an interest to me, but mainly on account of its severity. It does not always occur, but when present it is a grave symptom. I have been in the habit of teaching that three febrile diseases may be marked by the severest form of delirium, viz., rheumatic pericarditis, apical pneumonia, and typhus fever. I must not in this address pretend to give you reasons for this, I can only draw here your attention to the clinical symptom.

(3) That a tonsillitic form of rheumatism exists, I think all of you who have had much practice will agree. I have notes and records of quite a number of such cases. Rheumatic parents beget children, some of whom have typical joint attacks, some have severe tonsillitis, whilst in others attacks may alternate between tonsillitis annd arthritis, or tonsillitis and pericarditis. I cannot tell you why this should be, but I can only point out to you the clinical fact; and I can further supplement it by asserting that the exciting cause in such types is often sewer gas, or the effluvium emanating from manure heaps or other accumulations of decomposing filth.

There is, as yet undiscovered, some relation between the fauces and the joints, which is of extreme clinical interest. Besides the rheumatic tonsillitis, I would call to your mind the rheumatism of scarlet fever; the arthritis of hospital sore throat as examples of such associations.

(4) "The choreic variety of rheumatism" will be, I know, considered a very didactic term; but that the variety does exist I am fully convinced. Without wearying you with figures and details I would in support of this contention draw your attention to the following points: (*a*) Valve disease

is just as frequent (some of my figures show a greater frequency) after an attack of chorea as after an attack of acute rheumatism. (*b*) An attack of chorea may supervene on an attack of acute articular rheumatism; or (*c*) it may precede the joint affection. (*d*) Chorea attacks a child of a rheumatic stock, and thus often represents the rheumatic outbreak; figures which I am about to publish show this conclusively. The choreic patients who are the offspring of parents only one of whom is rheumatic, show a large percentage, which ratio is enormously increased in those children sprung from parents both of whom have had rheumatism. (*e*) Tonsillar sore throat is fairly common in children who have chorea. (*f*) The bodily temperature is often markedly above the normal line, and in such cases salicylates and bromides effect a speedy cure.

(5) Nodular growths may occur in some subjects as the only evidence and manifestation of rheumatism, or they may appear contemporaneously with a rheumatic arthritis. Although they are by no means unknown in an attack of acute rheumatism, for the most part they are indications of chronic rheumatism; but they tend to increase in size and become more painful during any subacute exacerbation of the parent disease. They are most frequently found in young children or in early adolescents. The favourite situations of these nodules is about the elbows, knuckles, along the vertebral borders of the scapulæ, round the knees and in tendons—in other words, wherever fibrous tissue is most developed. We are inclined to regard some of the forms of pericardial thickenings as coming under this category. Lastly, as proof of their rheumatic origin, they are frequently accompanied by valvular disease, although these two conditions may be the only rheumatic manifestations; but you will be surprised to find how more frequently they occur than one would suppose.

(6) Cutaneous eruptions, other than sudamina or miliaria, are met with in rheumatic subjects, or in those children descended from rheumatic ancestors. Erythema nodosum is most frequent, and probably urticaria comes next. One point I would draw your attention to, and it is this; although erythema nodosum is undoubtedly a rheumatic manifestation, it occurs for the most part in the children of the struggling poor, and is seldom seen amongst the rich. It would appear

to me to be a rheumatism which is influenced, or directed in a certain and distinct channel, by the surroundings of damp insanitary dwellings and unwholesome food. And the speedy relief afforded by appropriate treatment, as I shall point out to you, lends support to this view.

(7) The ocular evidences of rheumatism are for the most part confined to the muscular coat (rheumatic iritis). I take it that it is evidence of decay of muscular tissue rather than of nerve dystrophy. But do not fall into the error of regarding every iritis as syphilitic, even though a joint thickening may accompany the eye trouble. Iodides may clear up some of the inflammatory products of the iritis, but we should not necessarily condemn the sufferer as being syphilitic, but we should look for rheumatic evidence from joints, heart valves, nodules, and also from the family history.

(8) Muscular rheumatism not infrequently occurs by itself. It may show itself as a sharp attack, without peri- or endocardial inflammation; it may exist even without lesion, but as a rule the joints nearest the seat of greatest muscular pain are involved. But there is another and more frequent association of muscular rheumatism which is of great interest to practitioners working in districts in close propinquity to the Thames. I refer to the co-existence of muscular rheumatism with sciatica, tic, and other forms of neuralgiæ. I am convinced that the existence and therefore the influences of malaria in London are overlooked by many of us; and I have been accustomed now for some years to look suspiciously at lumbago, pleurodynia, sciatica, and to seek whether an old and unrecognised attack of mild ague may not be a factor in this peculiar form which rheumatism often takes in Hammersmith, Fulham, and Chiswick; and especially so if I find that these painful maladies do not yield to ordinary treatment.

Treatment.—I fear that so disjointed and short a lecture will be a disappointment to you; nor am I satisfied that I can remove the disappointment by telling you aught that is new in the treatment of rheumatism. But I can at least let you know my experience gathered from a large out-patient practice.

The treatment of acute rheumatism is still a matter of controversy. The older method of prescribing large doses of alkalies (bicarbonate of potash principally), either in small concentrated doses or as copious libations, still has its

advocates. But I am convinced that the verdict of a majority of the profession is in favour of salicylic acid and its salts, especially sodium salicylate, as the most efficacious remedies. It is on the other hand asserted that endocarditis is a more frequent complication when the patients have been treated by the salicylates, than occurs in another series treated by bicarbonates. On this point I would suggest that all of you record your results and let them be tabulated. An analysis of figures and statistics of patients treated at their own homes would, I venture to say, present some permanent interest, and show some contrast when compared and laid alongside similar series of cases treated in hospital.

The local treatment of acute rheumatism is not sufficiently advocated. I am in the habit of applying a blister wherever there are signs of rheumatic inflammation. I paint blister fluid on every inflamed joint, and I repeat the blister every other day. I apply a large blister over the precordium on the onset of the first abnormal sound; then when the blister has risen, I order it to be drained at the same time that the inflamed and painful skin is irrigated with a syringeful of solution of morphia (half strength.) The evidence of the sufferers themselves is that the smart sting of a blister is much easier to endure than the bursting sensation of a tense joint; that they prefer the acute tenderness of a blistered precordium to the dull, burning pain which previously existed. And, further, I am sure that vesicants have marked effects in two other directions: they diminish the length of time of the acute attack, and they also—which is more important—have a beneficial effect when applied over the precordium in lessening the probability of endo- and pericardial inflammation.

When endocardial inflammation is suspected I know of no treatment so imperative as prolonged rest; both bodily rest and physiological cardiac rest. I regard a heart which is threatened with endocarditis as being in that same category of urgent cases as a bone severely fractured, or as a ruptured vessel. In each case prolonged rest is the great cure. So I keep my patients in bed, taking small doses of digitalis for six weeks at least, or until he rebelliously demands his discharge. Even then I have been chagrined to find patients here and there return some six months later with obvious valvular disease, although at the time of their dismissal no murmur

whatever could be detected. Still I am happy to say that on the whole the results of such discipline are highly satisfactory.

The tonsillitis of rheumatism is best treated, locally, by means of astringent gargles. I would only suggest that the gargles will be found more efficacious and grateful to the patient if they are used in conjunction with hot water. There is one drug, however, which at the same time is a local astringent, and has a constitutional effect against rheumatism. I refer to guaiacum. Its effects at times are almost miraculous, but as it is a nauseous drug you must exert your own ingenuity in providing some vehicle in which to disguise its taste. In chorea with a rheumatic history I invariably prescribe the salicylates if there be any rise of temperature; otherwise I fall back on the well-known drug arsenic, as being the best of many vaunted remedies.

Nodular rheumatism, and also cases of rheumatism with erythema, appear to me to demand not only local treatment but constitutional restoratives. The patients for the most part are poor and ill-fed, and therefore cod liver oil with iron give good results. The nodules themselves may be painted with iodine, and also a prolonged course of iodides may be necessary. One bit of experience may be novel to you: I generally find that nitrate of potash cures the erythema nodosum in a few days. This treatment is purely empirical as I know nothing of the *rationale* of its action.

Muscular rheumatism is benefited by hot baths, to which soda, or brine, or sulphur may be added with advantage. I would also draw your attention to the relief which is afforded by the application of sponges wrung out in boiling water, and applied to certain tender spots, which will be found not only at the sites of superficial nerves, but also at bony attachments of the muscles.

Typical illustrative cases were then shown.

GERMS IN MOTHER'S MILK.—Cohen and Neumann found germs in healthy breast-milk, even after taking every antiseptic precaution in relation to the nipples. Honigmann, Knochenstein and Palleske have observed pus-producing germs in the milk of a large proportion of nursing women.

Report of Proceedings.

Ordinary Meeting—October 2, 1896.

W. BRUCE CLARKE, M.B., F.R.C.S., President, in the Chair.

The PRESIDENT delivered his opening address (see p. 1.)

Mr. LAWRENCE: I have much pleasure in proposing, and I ask you to join with me in giving, a hearty vote of thanks to our President for his very able and interesting address. The subject is one of every-day interest, illustrating the usefulness of regular exercise of muscles, and the necessity of exercising muscles in certain diseases.

We congratulate Mr. Bruce Clarke on his accession to the Presidential chair, and ourselves on having him to preside over us during the present session.

Dr. SYMONS ECCLES: I have much pleasure in seconding the vote of thanks to the President. All who have heard this able address must be impressed with its value, not only as a contribution to medical literature in general, but particularly to the annals of the Society, in which the members must congratulate themselves on finding for future consideration and study this interesting and instructive record of the catholicity which pertained to the work and writings of Mr. Bruce Clarke. Personally, I desire to thank the President for his courteous reference to the address which I had the honour to read last year when occupying the distinguished position now so well filled by Mr. Bruce Clarke, to whom I offer the thanks of the meeting with the felicitations which all feel and desire for the President and the Society during his year of office.

The vote of thanks was carried by acclamation.

The PRESIDENT: I have to return you my best thanks for the kind attention which you have given me this evening, and I need scarcely say that I thoroughly appreciate the vote which you have just so kindly passed.

Ordinary Meeting—November 6, 1896.

W. BRUCE CLARKE, M.B., F.R.C.S., President in the Chair.

Mr. F. BOWREMAN JESSETT read a paper with the notes of a case, on "Fæcal Fistula, due to self mutilation, occurring twice in the same patient," which is published in full on page 21.

Dr. HENRY SUTHERLAND: I desire to direct attention to the point raised in Mr. Jessett's paper regarding the rapid recovery of lunatics from operations. I have had recently under my care a male patient, who had been operated on for renal calculus. The operation was performed six weeks before admission into the hospital. The wound healed well, but the patient immediately suffered from an attack of mania. The attack lasted four weeks, after which he was discharged mentally recovered.

Mr. SWINFORD EDWARDS: I am interested to hear that Mr. Jessett's patient has undergone laparotomy no less than five times, and I am anxious to know whether this has had any effect on her present mental condition. I do not quite understand why Mr. Jessett on both occasions enlarged the fistula before performing enterectomy. I agree with Mr. Jessett that Mayo Robson's bobbin is an excellent device, although personally I prefer that suggested by Allingham. Any method which shortens the time necessary for intestinal anastomosis is to be preferred, provided that it is efficient.

Dr. ALDERSON: I have occasionally been struck with the fortitude that some mental patients display while being operated upon. For several years I had under my care an elderly lady *certificated*, who recovered quickly after surgical treatment. I remember removing from her tonsil a calculus (which I showed at this Society), and she hardly flinched, although I had to incise the tonsil first; and on several occasions I have opened sinuses and incised abscesses that had formed in her leg and foot from necrosed bone, and always without any anæsthetic, and I could but notice her comparative calmness and somewhat insusceptibility to pain. Ultimately this lady underwent at 68 an operation for ovariotomy, or rather the tumour proved to be a very large fibro-cystic growth, and for the first day or two she progressed well and appeared to be recovering from the operation; she died, I regret to say, at the end of the week, from pulmonary congestion and peritonitis, but certainly not from shock.

Mr. MCADAM ECCLES: I wish to ask Mr. Jessett what operation he considers the best in cases of fistulæ connected with the cæcum. I think such cases much more difficult to

deal with than those connected with the small intestine. Again, is anastomosis of the large with the large intestine and removal of the cæcum good, or is the short circuiting method and leaving the cæcum *in situ* a better operation?

Dr. TRAVERS: I shall be glad to hear what was the mental state of the patient before her first operation. I have not infrequently observed a mental change after double oöphorectomy.

Mr. JESSETT: I did not know the condition of the patient's mind before the first operation of removal of her ovaries. There is no doubt, however, that in young women the removal of the ovaries and tubes often upset the balance of the nervous system, and patients become melancholic. I have observed this on several occasions, but after a time the patients quite recover. I have noticed the same condition after removal of a myomatous uterus. I do not see any advantage in Allingham's bobbin over Mayo Robson's, but I think, by using one or the other, the operation can be very much more quickly performed than by Maunsell's or any other operation. If the fistula is connected with the cæcum and is small, I believe by thoroughly cleansing the bowels and keeping the patient on a restricted diet, it is quite sufficient to pare the edges and introduce a row of catgut sutures through the deep parts, and some deep silkworm gut sutures through the skin and muscular tissues. Should the fistula be very extensive, however, I would recommend ileo-colotomy to be performed, fixing the ileum high up in the ascending colon either by lateral apposition or by implantation.

The Treatment of Intra-Peritoneal Hæmorrhage.

Dr. MANSELL-MOULLIN read a paper with the above title, which is published on page 13.

Dr. EDEN: I wish to ask Dr. Moullin what he considers is the anatomical source of the hæmorrhage in cases such as those which he has described, where the tube is not ruptured and the ovum not expelled? It is difficult to understand in such cases what could have been the source of the considerable hæmorrhage which occurred. It is possible, however, that the ovum, although not expelled from the tube, is detached from the tube wall, and free bleeding then occurs from the placental site.

Dr. DOBSON: As an illustration of the difficulties arising in the diagnosis of internal hæmorrhage, I would refer to a case which lately came under my own observation. A patient, two months pregnant, took twelve compound colocynth pills, and then repeatedly climbed up and jumped off a garden wall. She was seized with acute pain and vomiting, the

symptoms being ascribed by the friends to the medicine. I was not called to see her until after the lapse of ten hours, when she was moribund. She died shortly after my arrival. The necropsy showed a tubal pregnancy which had ruptured into the abdominal cavity.

Dr. ROBINSON: I think that contractions of the Fallopian tube assist in causing the hæmorrhage.

Mr. KEETLEY: The unfavourable conditions under which it is justifiable to perform laparotomy for intra-peritoneal hæmorrhage are illustrated by a case dealt with in the hospital about a month ago. The abdomen was distended to its utmost, the gums blanched and the pulse not to be felt. On opening the abdomen, blood and clots gushed out freely. A rent was felt in the left Fallopian tube, which was now clamped. It could not be brought into view for the blood and clots welling up as the abdominal wall subsided. The patient's condition improved immediately, while the clots were being gently scooped and sponged out from every crevice of the greater cavity of the peritoneum. After a thorough process of this sort, the peritoneal cavity was filled with as much warm weak saline solution as it would retain with the laparotomy wound still wide open. The torn appendix was tied and removed. The radial pulse did not return till 10 a.m. the next morning (sixteen hours after operation.) Convalescence was uninterrupted. Dr. Robinson, who kindly examined the specimen, pronounced it to be one of ruptured tubal pregnancy. Only six weeks had elapsed since the last period, and two years since the last pregnancy. The intra-peritoneal injection of saline solution served, of course, as a substitute for intra-venous transfusion.

Dr. MACNAUGHTON JONES: I think it necessary to point out the vagueness with which the term "hæmatocele" is frequently used, inasmuch as it is applied to any and almost every form of pelvic hæmorrhage. A hæmatoma or escape of blood into the cellular tissue of the meso-metria being often thus confounded with intra-peritoneal hæmorrhage, it would be better to employ the term "pelvic hæmorrhage," dividing it into extra-peritoneal and intra-peritoneal, reserving that of hæmatocele for such collections of blood as are confined by a saccular envelope, keeping as quite distinct hæmorrhage arising as a result of ectopic gestation. One of our principal gains from recent knowledge is the certainty that intra-peritoneal hæmorrhage results more frequently from tubal gestation and from ectopic gestation generally than from any other cause. But other conditions give rise to bleeding most difficult to diagnose from tubal pregnancy. I have seen examples of blood cysts from the ovary, and hæmorrhage into

a large ovarian sac from actual rotation of the pedicle. It is most difficult to differentiate a tubal gestation sac from a hæmorrhage between the layers of the broad ligament. Dr. Mansell-Moullin has not entered into the question of alternative and expectant treatment in cases of intra-peritoneal hæmorrhage, or the prudence, or otherwise, of evacuating a pelvic hæmatocele. I think the general tendency now is either not to interfere or to perform cœliotomy. The more we know of intra-peritoneal hæmorrhage the stronger become the grounds for the performance of cœliotomy.

Dr. McCann: I think the thanks of the Society are due to Dr. Mansell-Moullin for bringing before us this evening a subject of great interest and practical importance. When dealing with cases of intra-peritoneal hæmorrhage care should be exercised in order to arrive at an accurate diagnosis; at the same time it is important for the operator to be prepared to deal with the other causes of internal hæmorrhage before opening the abdomen. A ruptured tubal gestation is closely simulated by a ruptured gastric or intestinal ulcer, a ruptured pyosalpinx, or acute axial rotation of an ovarian tumour. In making a diagnosis of tubal pregnancy, reliance should be placed on the following signs and symptoms: (1) paroxysmal pain in the lower abdomen; (2) early signs of pregnancy; (3) previous sterility; (4) irregular hæmorrhages from the vagina, with occasional passage of a decidual membrane; (5) bimanually a swelling situated to one side and behind the uterus, together with uterine enlargement.

As to the importance of salpingitis as a cause of tubal pregnancy, two opposite views exist. It must, however, be admitted that really very little is known concerning the etiology, as it has not yet been determined where the ovum meets the spermatozoon, or the laws which govern the process. I would urge the importance of a ring-shaped swelling around the rectum as a diagnostic sign of the effusion of blood into the left broad ligament. As to the advisability of operating where great shock exists, I think that preliminary infusion of saline fluid should be more extensively tried in such cases.

Mr. Malcolm: I am of opinion that if a patient is in a state of extreme collapse, and there is a fairly definite diagnosis of intra-peritoneal hæmorrhage from rupture of an extra-uterine fœtation, there should be no delay in operating and arresting the hæmorrhage. I have seen hæmorrhage limited by adherent intestine in a case in which the tube had ruptured. I think this more rare than the cases in which blood escapes from the ostium of the tube and becomes circumscribed.

Dr. MANSELL MOULLIN: I believe if the symptoms to which I have directed attention were sufficiently impressed upon the minds of those engaged in general practice, that many cases which at present escape a definite diagnosis would be recognised as cases of minor intra-pelvic hæmorrhage. Many such cases recover with prolonged rest, but whenever the hæmorrhage is considerable I would urge the advantages of operative treatment. I concur with the view expressed by Dr. McCann, that separation of the placenta is the primary cause of the hæmorrhage and destruction of the ovum. It is, however, only a conjecture. The sudden onset of pain—the most characteristic feature of the case—still requires an explanation. Mr. Keetley has mentioned an interesting case of profuse internal hæmorrhage, on which the patient appeared to revive when the clots were removed from the abdominal cavity. I must congratulate him on the satisfactory result, but I think it is not a factor on which much reliance can be placed, when called upon to decide the line of treatment. When a patient is so far gone I consider an operation would only increase the shock.

[The time-limit of the meeting having been reached, Dr. Mansell Moullin concluded by thanking the members of the Society for the kind attention which they had given to his paper.]

CLINICAL EVENING.

W. BRUCE CLARKE, M.B., F.R.C.S., President, in the Chair.
December 4, 1896.

Dr. HENRY SUTHERLAND: I have here a case of multiple lipomata in a woman, aged 58. The tumours are distributed all over the body, both internally as well as externally. They have existed since the patient's birth, and have been attributed by her to the effect of a maternal impression. The next case is one of varicose veins in a woman, aged 40. The veins form a complete network over the thighs and legs. The patient's mother and two married sisters are similarly affected. She attributes the disease to the too frequent use of hot baths. The third case is one of supernumerary nipple, which is situated below the ordinary nipple of the left breast. On pressure milk can be expressed from the supernumerary structure.

Mr. SWINFORD EDWARDS: I think the case of varicose veins one eminently fitted for operation. As to the case of

supernumerary nipple, I am inclined to differ from Dr. Sutherland's view, and look upon it as an example of galactoferous fistula. I doubt very much if any erectile tissue would be found in the small papilla.

Dr. SHUTTLEWORTH: I had under my care an idiot boy who had a girdle of fatty tumours (multiple lipomata) 10 to 12 inches in width around his loins. In addition, the skin of the affected part was covered with a growth of hair (brown and black), like that of a cow. The mother gave a history of "maternal impression," being knocked down and trampled on by a cow.

Mr. KEETLEY: My experience leads me to formulate the following rules in the treatment of varicose veins: (1) If possible, avoid elastic knee caps and thigh pieces. As a rule prefer to them excision of varicose veins in the knee and thigh; (2) an elastic stocking is greatly improved if made to lace up; (3) except when the veins are inflamed, prescribe exercise, not rest; (4) keep the legs cool, and do not overheat the feet.

Facial Hemiatrophy.

Dr. GEORGE JOHNSTON: This patient, aged 21 years, noticed sixteen months ago that the left side of her face was getting thinner than the right. The difference between the two sides has become slowly but steadily more marked. The left side is sunken over the upper jaw and teeth, and the malar bone stands out prominently from wasting of the tissues. On first inspection the muscles appear to be involved, still they act freely and their electrical reaction is normal. The skin is paler and smoother than that of the sound side. I do not think the bones are at all involved in the atrophy. As to the cause of the condition in this case none can be traced. No other member of her family has been similarly affected. No blow or injury has been received and no severe illness preceded the onset of the malady. Sensibility is not affected, the disease being painless since its onset. There is no affection of taste.

Mr. KEETLEY: The atrophy seems almost entirely confined to the fat of the cheek. Would such general treatment as that which goes by the name of Weir-Mitchell's be worth trying?

Mr. LLOYD: Would Dr. Johnston tell us the treatment employed and the effect produced?

Dr. JOHNSTON: The disease being so very localised and the skin being involved in the atrophy as well as the subcutaneous fat, I am afraid that Weir-Mitchell treatment would not be of much avail. The patient has only been under observation a

fortnight. Treatment of these cases is usually unsatisfactory. Possibly hypodermic injection of strychnine might be of use should the nucleus of the nerve be the seat of the lesion.

Fracture of Epiphysis of Lower End of the Humerus, with Radiograph.

Dr. CAMPBELL POPE: This patient, aged 8, fell off a stool on August 3. There was great deformity of the elbow simulating dislocation backwards. There was crepitus with comparative ease of reduction and resumption of the deformity when let alone. The parts were very difficult to keep in position owing to the restlessness of the patient. A radiograph was taken by Dr. Low on November 5. Thickening above the elbow joint in front and a depression behind simulating the olecranon fossa are shown. The true cause is indicated by the radiograph which exposes a mass of callus extending into the joint. It also shows the necessity of keeping the lower fragment well forward.

Mr. MCADAM ECCLES: I quite agree with Dr. Campbell Pope that the radiograph well shows the injury which has occurred. I think the fracture in this case is so much above the situation of the centre of ossification of the lower epiphysis of the humerus, that the real line of fracture is at a higher level than that of the epiphyseal line. Further, it would seem that in addition to the displacement backwards there has been some rotation backwards.

Dr. POPE: I wish to know if Mr. Eccles considers that the fracture of an epiphysis occurs close to the centre of ossification. I myself consider that the fracture would occur some distance above the centre of ossification.

Two Cases of Congenital Dislocation of the Right Hip.

Mr. KEETLEY: This patient, a girl aged 13 years, has congenital dislocation of the right hip joint. Owing to the position of the femoral head nearly up to the crest of the ilium on the dorsum of that bone, the limb was shortened 3½ ins. By division of the straight head of the rectus, some other tense muscular fibres and fascia, and the anterior part of the capsule, together with extension gradually increased to 16 lbs. (which was comfortably borne), the shortening was reduced to 1½ ins.

Three days previously under ether an extension of 84lbs. (6 stones) was applied for twenty minutes, which reduced the shortening to ¾ in.

A part of this is doubtless due to mal-development of the head and neck. There is no acetabulum. Next week I

propose to make an acetabulum in the proper position, and hope to be able to place the head of the femur in it.[1]

(2) This, a child aged 3 years, has also congenital dislocation of the hip. I have succeeded in reducing the head of the left femur (the side affected) and am keeping it *in situ* by the use of plaster of Paris, in order to maintain a position of abduction. I intend to follow in the further treatment of this case the methods of Lorenz.

Mr. SAVAGE: Would Mr. Keetley kindly explain how he intends to make an acetabulum?

Mr. C. M. TUKE: Having seen the first case some months ago before treatment was commenced, I am extremely interested in it. I would ask Mr. Keetley whether there is in consequence of want of use, some co-existing want of development of the bones of the dislocated limb, which might account for some portion of the shortening. Mr. Keetley did not, I think, mention the point, but no doubt it was taken into consideration.

Mr. KEETLEY: In making the acetabulum I intend to use the gouge, mallet, and a strong Volkman's spoon, and to obtain a sharp edge at the upper and outer border with the aid of a small circular saw worked by a surgical engine. A dental friend of mine, Mr. Macdonald, has suggested a gold acetabulum. The idea is worth considering, as it could be let into and fixed in the bone and could be polished to great smoothness. Mr. Charles Tuke is right in thinking that there is some lack of development about the femoral head and neck, but it is not excessive.

A Case of Cretinism.

Dr. CHARLES W. CHAPMAN: This patient, aged 18½ years, was shown on March 6, 1895, and reported in the WEST LONDON MEDICAL JOURNAL for April, 1896. The improvement under thyroid treatment during nine months is as follows:—

In three weeks the swelling of the face, tongue and abdomen was much reduced.

In six weeks new hair appeared, and she was much warmer, the skin being less harsh.

In twelve weeks a quantity of new hair had developed; she was one inch taller; she tried to talk. Bowels acted without aperient; had more control over her bladder.

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[1] This proposed operation was carried out by Mr. Keetley. He made a new acetabulum and reduced the dislocation, the child having no untoward symptom afterwards.—[ED.]

In twenty weeks could walk—leaning on the perambulator —for a quarter of a mile.

In twenty-four weeks could at times give warning of impending action of the bowels.

In thirty-six weeks two new well-formed white teeth in the upper jaw next appeared, and one in the lower jaw had become white and strong. She is now much more intelligent and happy; has grown altogether three and a-half inches. Her head is covered thickly with fine glossy hair.

Dr. SHUTTLEWORTH: I congratulate Dr. Chapman on the result of the treatment in this patient, whom I saw nine weeks ago in her original degenerate state. She might justly have been described as a "toad-like caricature of humanity." The growth (three inches in nine months) accords with the experience of others, *e.g.*, Dr. John Thomson of Edinburgh. As to the rate of growth at that age, the rule is that physical and mental improvement is in inverse ratio to the age. One practical point brought out at the British Medical Association discussion at Carlisle on this subject was, that even at mature age growth of the long bones might be so rapid that a condition resembling rickets was apt to result, and if the patient be allowed to walk too much at an early period of improvement, bowing of the legs is apt to occur. I notice a marked improvement in intelligence, which I do not think has reached its limit.

A Case of Ovariotomy, with Hæmorrhage from Abdominal Scar during Menstruation.

CASE.

Dr. DRUMMOND ROBINSON: The following are the notes of this case:—

H. D., aged 43 years, married twenty years; never pregnant; husband alive. Catamenia regular until three months ago; for last three months amenorrhœa.

In 1877 she was operated on in the West London Hospital, and an ovarian cyst weighing 20 lbs. was removed. The pedicle was treated extra-abdominally, being clamped in the lower part of the abdominal wound. A belt has always been used, but for the last two years there has been some protruding of the lower part of the abdominal scar.

Lately the patient has experienced some pain in the back, and giddiness, and has attended the out-patient department of this Hospital (West London) under my care. The cervix uteri is small (senile), and the uterus, on bimanual examination, is also small (sound passes less than two inches), freely movable and in no way tethered to the abdominal wall. Nothing abnormal is found in the pelvis.

There is a hernia of the lower part of the abdominal scar. The lower part of the scar below the hernia presents an elevated nodular appearance which, according to the patient, represents the pedicle of the ovarian cyst removed in 1877. She states that since the operation the monthly periods have been quite regular until three months ago. She further states that during each menstrual period, since the operation, there has been a discharge of blood both from the vagina and also from the lower part of the nodular area above-mentioned, in the abdominal scar.

This case is interesting from several points of view. It shows the marked improvements made in the technique of ovariotomy during the past twenty years. Formerly all cases were treated by the clamp, now all cases are treated by ligature and the pedicle is dropped back into the abdomen.

This case also illustrates a fact mentioned by Sir Spencer Wells, namely, that under certain circumstances blood oozes from the Fallopian tube during menstruation. In this instance there is a spot in the lower part of the abdominal scar that looks like the cut end of a Fallopian tube—it is too small to allow the passage of a probe.

Whether the blood in this patient comes from the walls of the tube or regurgitates from the uterine cavity I do not feel myself competent to say. All are agreed that during menstruation blood oozes from the uterine mucous surface. Some would maintain that this also takes place from the mucous lining of the tubes. Such a case as the one now shown lends some colour to this view, but as has been pointed out, it is quite possible that the blood really comes from the uterine cavity, and has regurgitated through the cut tube. Again, if tubal menstruation were the rule, all tubes blocked at their orifices and distended by retained secretions should contain blood, but this was found not to be the case.

Mr. LLOYD: I think the case is an example of vicarious menstruation.

A Case of Nephrolithotomy.

Dr. R. PERCY PATON: The following are the notes of this case:—

John Pack, aged 48, lead pipe maker, came under my care April 16, 1896, with a history of eight to nine months' loss of flesh, and that during that time his urine had been thick and discoloured. He had never had any pain. He had been in the infirmary for a month, but discharged himself.

On examination, a tumour was felt in the left loin, which was obviously a moderately enlarged kidney, which, however,

was not tender, and felt of about normal consistence. The urine was acid, contained albumen and pus, but no blood. Micturition was rather frequent. No other physical signs of importance were found, except that his temperature went up every night almost to between 99° and 100°, and he was steadily losing flesh. No tubercle bacilli could be found in the urine.

It having been decided to explore the kidney, I made the usual lumbar incision on May 11, and on exposing the viscus and puncturing it, some foul urinous pus escaped. On enlarging the puncture and inserting the finger, the kidney was found to consist of much-dilated thickened calyces, fixed in one of which was the stone now shown, which was with some difficulty removed. The kidney was then fixed to the wound and a large tube put in. The stone was found to weigh 7 drachms 10 grs. From this time the patient did well. No more pus passed in the urine, and except that once the wound had to be dilated to get better drainage, he made an uninterrupted recovery and was discharged on July 9, 1896.

I have also here the rectum and bladder of a boy aged 12. There are two ragged tears in the bladder, one between it and the rectum, the other through its fundus and peritoneal covering. A white glass rod has been passed from the rectum into the bladder and then out through the peritoneal tear. The bladder has been opened anteriorly, the rectum posteriorly. The piece of cloth in the rectal opening is a square inch of tweed trousers, which should in the specimen have been placed in the bladder, as it was found there *post-mortem*.

The injury was caused by accidentally slipping while leaning in a sitting position on a sharp stick, previously to which he had not micturated for about twelve hours. He removed the stick himself and went home, and says he was then able to pass water. The accident happened at 5 one evening, and he was not seen by any doctor till next day. He was then able to pass a little urine with great pain. When seen by me at 9 p.m. the day after the accident he was delirious and obviously suffering from peritonitis, but although operative interference was pressed for the father refused permission, and the patient died the same night.

Mr. SWINFORD EDWARDS: It is now eight months since the operation of nephrolithotomy was performed upon the patient, and yet a fistulous track is still left. I would offer as a reason for this the fact that the pelvis of the kidney was drained by a tube passed into its interior. Where rapid healing is desired, I think the tube had better not be passed into the kidney, but merely down to it. In cases of nephrolithotomy this has been my invariable habit, the discharge

of urine usually ceasing from the loin within two to three weeks.

Dr. PATON: The reason for putting a tube into the pelvis of the kidney was that the stone being broken in removal, it was uncertain whether all the fragments were cleared out. This method of treatment was justified by the fact that some fragments were washed away by irrigation later, and also that as soon as the drain was removed the temperature rose until time had been allowed for the suppurative pyelitis to settle down.

Multiple Exostoses.

Mr. MCADAM ECCLES: This patient is a girl aged 16; her father and two brothers are similarly affected, but no other family history can be obtained. There is no history of rheumatism or of syphilis.

Some of the exostoses to be observed in this patient, are:—*Right hand*, the *first phalanges* of each finger, also second and fourth metacarpals; *left hand*, first phalanx of second, third and fourth fingers; *lower end of right radius; right humerus*, upper end; *right clavicle*, outer end; *lower end of femur*, right and left; *upper end of tibia*, right and left; *right tibia*, lower end.

The second patient is a boy aged 13. His father, one brother and one sister are affected. When he was about 2 years of age the parents noticed swellings about the limbs, particularly one on the right femur.

Some of the exostoses noticed:—Left and right clavicle, outer end; *left and right humerus*, upper end; *radius and ulna*, both lower ends, phalanges and metacarpals; *many on ribs;* on both *iliac crests; right femur*, middle and outer side of shaft; lower end of both *femora;* upper end of both tibiæ and fibulæ; lower end of both tibiæ and fibulæ; *feet*, phalanges and metatarsals.

The PRESIDENT: The elder brother of the last patient has been under his care, and I believe that he was one of the most remarkable cases of exostoses in existence. One of my dressers counted more exostoses upon him than there were days in the year. I myself removed upwards of thirty exostoses because they interfered with his power of locomotion, *e.g.*, he had exostoses on the under side of each os calcis. Round his knee there were a large number of bony growths, which knocked against one another when he walked, and therefore required removal. Several other joints were limited in their movements owing to this outgrowth of exostoses. Some had to be removed from the pelvis because he could not lie down. When I last saw the patient he had nearly reached 24 years of age, which is about the limit of exostosis growth, and I believe no fresh ones have occurred.

Right Hemiplegia.

Dr. SEYMOUR TAYLOR: This patient, aged 50, complains of loss of power and of sensation on the right side. The onset occurred suddenly during night, twelve days ago, without convulsions. He has no aphasia. No marked palsy of face or tongue. No hemianopia. There is only slight loss of sensation. He is already showing signs of recovery, commencing in the upper extremity. The cause of the hemiplegia is a small hæmorrhage in the posterior part of the internal capsule, from the posterior cerebral artery. The diagnosis is based on these grounds. He has signs of renal disease. His age is favourable for hæmorrhage. He has no valvular disease of the heart. The motor affection is more pronounced than the sensory affection. The paralysis of the leg is worse than that of the arm, which again is worse than that of the face.

Obituary.

WILLIAM FRANCIS AINSWORTH, F.S.A., F.R.G.S., L.R.C.S.Edin.

AN old, esteemed and distinguished member of the Society—Mr. William Francis Ainsworth—passed away last month. He was one of our original members. His appearance probably was not well known to the members beyond those directly connected with the West London Hospital. But his quiet dignified presence, his keen, kindly and handsome features, his cheerfulness and good comradeship, will not readily be forgotten by the younger generation of the staff, with whom his official duties happened to bring him into contact. Mr. Ainsworth died full of years, having reached the age of 89. The failure in his health had only recently occurred. Despite his mental and physical activity he passed a singularly healthy life. Like his famous cousin, Harrison Ainsworth, his tastes were all literary. We know not whether he ever practised his profession, but it is certain that his large contributions to the literature of travelling and exploration testify very plainly to his capacities as a writer, observer and original thinker. In 1841 he published "Travels in Asia Minor, Mesopotamia and Armenia to the Oriental Christians;" "Lares and Penates, or Cilicia and its Governors;" "The Euphrates Valley Route to India;" "On an Indo-European Telegraph by the Valley

of the Indus" (since carried out by the Government). In 1853 he was elected a Fellow of the Society of Antiquaries, with which body he maintained his connexion till his death. In 1854 he edited Xenophon's "Anabasis and Memorabilia," in Bohn's Classical Library; also in 1861 "All Round the World," and the "Illustrated Universal Gazette." In 1888 he published "A Personal Narrative of the Euphrates Expedition," and in 1890 "The River Karum." The degrees of M.A., Ph.D., Philadelphia were conferred upon him in 1871. He was associated with many learned Societies other than those already mentioned, British and foreign. Again he was one of the founders of the West London Hospital, of which he was also the first Hon. Secretary for many years, and subsequently until his death the Hon. Treasurer and a Vice-President. For many years he took an active part in the parochial affairs of Hammersmith. In politics he was one of the leading Conservatives of his district in the old borough of Chelsea and the western districts of Middlesex, and in the early days of the new borough of Hammersmith. His correspondence was very heavy, persons from all parts of the world seeking information from him upon points of scientific interest and antiquarian research. He leaves surviving him one son and two daughters; one of his daughters is the wife of Mr. R. J. Gilbert, the excellent Secretary of the West London Hospital. He possessed a very generous and kindly disposition, so that he always entertained an open ear for all the troubles of those who came to him. It was often that he rendered pecuniary assistance to applicants who sought his aid to an extent, perhaps, that was not wise so far as his own interests were concerned.

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TREATMENT OF BONE CAVITIES AFTER SEQUESTROTOMY, &c.—Neuber describes the various methods of treating cavities in bones left after sequestrotomy or similar operations, including turning in of skin, blood-clot, implantation of bone, decalcified bone, &c. He considers the use of iodoform important in these cases, and employs an emulsion in starch. This is made of wheat starch, 10 gme. being mixed with a very little cold water, and 200 gme. boiling hot 2 per cent. carbolic-acid solution being added, with 10 gme. iodoform stirred in. On cooling, this makes an even, yellow, jelly-like mass, which melts at the temperature of the room, but can be maintained unaltered for weeks, except that it becomes a little more fluid. The iodoform changes a little with exposure to light, so that it should be kept in the dark. Excellent results were obtained with this method, all but 3 of 22 cases healing by first intention.—*Aertzliche Rundschau*, October 15, 1895, p. 657.

The Mirror of Practice.

TWO OPERATIONS FOR APPENDICITIS, PRESENTING UNUSUAL FEATURES.

By Leonard A. Bidwell, F.R.C.S.
Senior Assistant Surgeon, West London Hospital.

The notes of the following cases I have thought will be read with interest by the members of the Society:—

Appendicitis; Abscess near Umbilicus; Excision of Appendix; Cure.

Case 1.—F., aged 18, was admitted under the care of Dr. Turner on August 21, 1896. She was previously under treatment in the out-patient department for hæmatemesis and anæmia, and she was admitted on account of severe abdominal pain. A tumour was noticed in the right lumbar and umbilical regions. Its lower border was nearly on a level with the umbilicus. There was no distinct fluctuation, but palpation was painful. The right iliac fossa was quite empty. The temperature was 101°, and the tongue furred. The previous history of hæmatemesis, together with the sudden attack of abdominal pain, suggested the possibility of a ruptured gastric ulcer, so I made an exploratory incision in the middle line above the umbilicus. The stomach was quite healthy, and the tumour was found to be connected with the cæcum, so the abdominal incision was closed with sutures, and another opening made over the tumour; an abscess cavity was reached, and the vermiform appendix was found perforated. It was ligatured and removed, and a drainage tube was inserted down to the cæcum. There was no fæcal discharge, and the patient made a rapid recovery, leaving the hospital in three weeks with both wounds quite healed.

Appendicitis; Abscess; Excision of Appendix; Round Worm found in Dressings; Cure.

Case 2.—A. K., aged 14 years, was admitted into the West London Hospital on July 22, 1895, from Dr. Taylor's out-patient room. For six weeks the patient had suffered from irregularity of the bowels and abdominal pain, which had been worse for the last fourteen days. On admission there was a swelling, about the size of a hen's egg, in the right iliac fossa. Fluctuation was obtained. Chloroform was given, and an incision made over the swelling, evacuating about ʒiii. of fœtid

pus. At the bottom of the cavity a narrow opening was found which ran down towards the cæcum. The opening was dilated up and the deeper cavity explored with the finger. At the bottom of this the vermiform appendix was found, and was separated from its adhesions and ligatured close to the cæcum. A perforation was found in its walls. A drainage tube was passed down to the cæcum, and the edges of the wound brought together with three silkworm gut sutures. On the following day the wound was dressed and a copious quantity of feculent pus escaped. On July 24, on removing the dressings, a live round worm was found lying inside the dressings near to the wound, and there was a considerable discharge of fæces. The wound was dressed twice daily, and the fæcal discharge continued till July 27, when the tube was removed as there was only a little mucus in the dressing. The wound was partially healed by August 11, and the patient left the hospital on August 14 quite well.

Remarks.—These two cases, though examples of a condition which is only too common, have certain points which make them specially interesting. In the first case the diagnosis was obscure: first, because of the history of previous treatment for hæmatemesis and anæmia; and secondly, because of the position of the swelling. Although the swelling probably contained pus, I thought it best not to cut down directly upon it in case a coil of intestine should be adherent between the abscess and the abdominal parietes. An exploratory laparotory, as was practised in the case, at once cleared up the nature and origin of the abscess, and as the exploratory opening was closed before the abscess was opened, no further risk was run.

In the second case I believe that the round worm, which was found in the dressings, came out of the wound and left the intestine by the open end of the vermiform appendix, since a discharge of fæces appeared in the dressings at the same time and stopped within two days after the exit of the worm. The part of the appendix to which the ligature was applied was rather rotten, so it is probable that the ligature cut through and so allowed the passage of the worm through the open end of the appendix. It was suggested that the worm might have been passed *per anum* and afterwards found its way under the dressings. I do not, however, think that this is possible, since the dressings were tightly applied and a fæcal discharge accompanied the worm. The worm was undoubtedly an *ascaris lumbricoides*, and I believe that this mode of exit is almost unique.

A CASE OF ACUTE RETENTION OF URINE SECONDARY TO PROLAPSE OF THE UTERUS AND VAGINA.

By G. Drummond Robinson, M.D., B.S.Lond., M.R.C.P.

Assistant Physician for Diseases of Women, West London Hospital; Physician to Out-Patients, British Lying-in Hospital.

A patient, aged 69, first suffered from prolapse of the uterus after the birth of her first child, which occurred when she was 44 years of age. During the next nine years she had six children, and the condition of the uterus was much improved. After she ceased bearing children the uterus became completely prolapsed, and remained so. Her work was very heavy and she was obliged to wrap a piece of cloth round the prolapsed uterus and vagina to protect them, but in spite of this there was generally some ulceration present.

This condition remained unaltered for twenty-two years, and in spite of it the patient was able to continue her work with comparatively little inconvenience.

In 1892 she first began to have trouble with her water. Micturition was frequent and but little urine was passed at a time; the desire to urinate had to be instantly obeyed or the water ran away from her.

On the evening of April 25, 1895, after a glass or two of beer she attempted to pass water and fæces and found herself unable to do either. She made many unsuccessful attempts to accomplish her purpose between this time and late in the afternoon of April 27, when I saw her.

The patient seemed to be in great pain, and it was impossible to make an abdominal examination. The vulval region was occupied by a dark blue globular mass, considerably larger than a fœtal head, the surface of which was everywhere covered with scars, the result of former ulceration. On the lower part of this mass was an orifice through which the little finger could be passed its whole length and the uterine sound $3\frac{1}{2}$ inches. The swelling was elastic and very tense, and fluctuation could easily be obtained at all parts of its surface, both in front and also behind. The orifice of the urethra could not be seen on account of the forward bulging of the mass, but its situation could be felt with the finger, and a bladder sound was, with some difficulty, passed backwards and downwards (the urethra being sharply bent in this direction), and its extremity could be felt at all parts of the swelling only separated by a thin layer of tissue from the examining finger. A catheter was now passed in the same direction as the sound, and about three pints of high coloured urine escaped. This caused the

walls of the vulval mass to become flaccid and enabled the parts to be thoroughly examined.

The cystic tumour consisted of the prolapsed vagina and cervix uteri, and it appeared to be everywhere lined by bladder. There was no rectocele. The elongated and very thin supra-vaginal portion of the cervix could then be felt by grasping the upper part of the tumour, but the fundus uteri could not be identified. The mass, which had previously resisted all efforts at reduction, was then easily replaced.

The patient suffered from an attack of cystitis, which gradually passed off, and a rubber ring was eventually inserted.

Prolapse of the uterus and vagina is one of the most common of the pathological conditions affecting the female genital organs, but in spite of this fact I think that there are some points connected with this case that are instructive, and worth considering. In the first place, this poor woman was enabled to earn her living throughout a period of some twenty years, by work which necessitated the carrying of heavy weights up long flights of stairs, although during all this time the uterus and vagina were completely prolapsed and generally covered with ulcers. No pain was felt, and so slight was the inconvenience experienced that the patient, when she sought medical advice, could not be induced to submit to any form of mechanical treatment. In estimating the importance of the "displacements" of the uterus, it is necessary that the great displacements—such as prolapse—should be studied. Complete prolapse is not always without symptoms, but when they do occur they generally result from the presence of the prolapsed mass in an inconvenient situation. Certainly the symptoms of this condition are neither so numerous nor so important as those assigned by some to the so-called "minor displacements" of the uterus.

Retention of urine is given in text-books as one of the symptoms of prolapse of the uterus. No doubt it frequently happens that under such circumstances it is impossible for the bladder to completely empty itself, and a small amount of urine may remain in the lower part of the prolapsed organ. In my experience, however, this condition very seldom leads to troublesome symptoms. Absolute obstruction to the urethra, as occurs frequently with fibroids and incarceration of a retroverted gravid uterus, is very seldom due to prolapse. This is the only instance of this condition that I have seen, although, as we all know, prolapse is extraordinarily common. In this case the urethra was sharply bent backwards and downwards, so that not a drop of urine could be voided, and it was with difficulty that a catheter was passed. In ordinary cases of prolapse with the bladder full, that organ can be

shown to be entirely limited to the anterior aspect of the prolapsed mass. In this case the whole of the prolapsed mass seemed to be lined with bladder. Whether the bladder had become dilated at its sides and so extended laterally round the cervix and uterus until it reached and distended the prolapsed posterior vaginal wall, or whether the fundus of the bladder dilated and extended into Douglas' pouch over the summit of the fundus uteri, and thence forced its way down between the uterus and posterior vaginal wall, I could not satisfy myself, although I tried to determine that point.

A recent continental writer has described two cases similar to the one I have recorded, in which he says the bladder became distended in the latter of the two ways above-mentioned—namely, the fundus of the bladder extended over the summit of the fundus uteri, and thence down between the uterus and vagina. The case here reported is of interest to me, and I think it may be so to others also.

A SEVERE CASE OF OCULAR MIGRAINE.

By Percy Dunn, F.R.C.S.

Assistant Ophthalmic Surgeon, West London Hospital.

Cases of ocular migraine are not uncommon, but a good deal of variety is shown in the degree of their severity. It so happens, however, that within the past few months several severe cases of the kind have come under my notice, all of which were speedily relieved by the ordinary treatment adopted. For the most part among hospital patients children appear to be the greatest sufferers, about the time when they reach the higher standards in the Board Schools. An interesting feature, and one which should always be borne in mind in connection with these cases, is that complaint is seldom made about the eyes. As a matter of fact the ocular symptoms proper are entirely masked by the migrainous ones; that is to say, a child naturally assumes that a difficulty in reading must be of quite secondary importance in comparison with a severe frontal and vertical headache, which generally supervenes soon after school work is commenced. Consequently attention is not directed to the eyes. I inquired among my patients how soon after beginning their work at school the headache would become troublesome, and the answer usually was within about an hour. Thus, under these circumstances, for the rest of the school hours the suffering children were compelled to continue their work, when, practically speaking, they were physically unfit for any such thing. The usual

absence of complaint about the eyes explains to a large extent the long interval which is often allowed to elapse before the patients come under the notice of an ophthalmic surgeon.

I append here the notes of a case which bear especially upon this point.

Clara S., a delicate looking little girl, aged 11, was brought by her mother to my out-patient room early in October last with the following history: For the past eighteen months she had been "ailing." She had lost flesh and colour, was nervous, excitable, and often out of spirits; almost every evening during this period she had come home from school complaining of headache and a feeling of sickness. Two or three times a week she would actually vomit, bringing up frothy mucus. On these occasions she would refuse all food and ask to be taken to bed. In the morning she would wake up feeling comparatively well, with no headache and ready to return to school. But in the evening she would reach home again suffering from a recurrence of the symptoms.

From time to time a tonic was prescribed for her, the mother believing that the child was only suffering from weakness. Ultimately, however, her medical man was consulted, who, after treating her for a short time without material benefit, sent her to me at the hospital, stating that he thought that her symptoms were due to some defect of vision.

The patient was found to be hypermetropic. Accordingly atropine drops (two grains to the ounce) were ordered to be instilled into each eye twice daily for a week. The effect of the drops was almost magical. From the time that they began to be used all the symptoms ceased. At her second visit the vision was tested, and with + 1·50 the child read $\frac{6}{6}$ with each eye. The glasses, + 0·75, were ordered to be used only while reading and near work were being done, and since then no further complaint has been made. Within the past few days I saw the child again; the report was that after the glasses had been procured she had attended school, and had continued to do her work without any discomfort.

POST-MORTEM CÆSAREAN SECTION.—Hoffman reports the case of a woman seized with eclampsia in the eighth month of her fourth pregnancy. Death ensued in the course of two and one-half hours. Cæsarean section was performed ten minutes after the last inspiration, resulting in the delivery of a living male child fifteen inches in length. Nourishment was administered to the child by means of a spoon, but in consequence of enfeebled vitality it died at the end of twenty-five hours.—*Centralbl. für Gynäkologie*, 1895, No. 50, p. 1,319.

Reviews and Notices of Books.

TUBBY ON DEFORMITIES.[1]

THIS important book, the author tells us, is the outcome of years of his own note-taking and observation. Mr. Tubby is to be congratulated, not only upon the care and precision of his methods, but also upon the clear and definite manner in which his knowledge and ripe experience have been placed at our disposal.

The confirmation of the author's wish, that his work "may be a trustworthy guide to medical men in the treatment of deformities" can be confidently predicted. No doubt the volume is a large one, but it would have been much larger had not Mr. Tubby so completely classified the subjects with which he was dealing. We have always thought "orthopædics" an important but rather a narrow branch of surgery, and although the contents of this volume compel us to modify the latter part of our view, we still cannot help feeling that with such discriminating powers in condensation, and with such ability in lucid description, the author has limited himself to too small a field of operation. The fact that so much that is interesting and instructive is made out of matter that is, comparatively speaking, plain and simple, speaks volumes for the astuteness and subtlety of Mr. Tubby's exposition. In the preface Mr. Tubby states that he cannot understand on what grounds orthopædic surgery in England includes tuberculosis and syphilis of the spine, and excludes the same diseases when they occur elsewhere. We do not pretend to see further into this matter than the author, and we can fully sympathise with specialism generally upon the question of where to draw the line, but with an equally justifiable want of understanding we may ask upon what grounds have these particular spinal affections been annexed by orthopædic surgery.

Indiscriminate tabulation alone is the work of a crammer, not of a teacher. This book is from the pen of a teacher, and tabulations chiefly occur (though not always) after full descriptions, and we trust those who may read this book will not be tempted to read the tabulations and to skip the descriptions; it would be better for them to skip the former and read the latter.

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[1] "Deformities:" a Treatise on Orthopædic Surgery, intended for Practitioners and advanced Students, by A. H. Tubby, M.D.Lond., F.R.C.S.Eng. Illustrated with 15 plates and 302 figures. London: Macmillan & Co., Limited, 1896.

The histories of patients are shortly and succinctly portrayed, and the cases palpably demonstrate those points in illustration of which they are inserted.

Allusion has been made to the author's powers of condensation. For an example of them the reader can be referred to Section III., wherein the whole subject of rickets is crystallised. It is a perfect little picture of the disease, and all its important landmarks are vigorously delineated.

The descriptive part of the work is divided into five sections, of which Section I. is the longest, and deals with spinal affections with great care and completeness.

In speaking of the value of pain as an element in the diagnosis of spinal tuberculosis, Mr. Tubby rightly says that the pain elicited by pressure upon spinous processes is not to be regarded as of value, because it is present in other conditions. This is so, but what is of real value in diagnosis is the pain elicited upon pressure over the *transverse* processes, for patients suffering from hysteria will not connect this part of the examination with the spine. Fortunately hysteria does not realise the exact extent of the spine's bony prominences.

In the management of spinal abscess (on p. 63), indications are given for the expectant treatment, but in our opinion they are all indications (except number 4) for immediate operation, provided the surgeon can trust himself and his methods as completely as he ought to be able to do. Therefore we would advise surgeons who are familiar with the ugly, dangerous and ignominious consequences of infection, to read and follow Mr. Tubby's rules for the expectant treatment. On the other hand, it is needless to advise trustworthy surgeons to shun them, for they will spontaneously disregard them.

Why is No. 4 inserted here at all? it advises active interference.

Upon pages 67 (thirteenth line) and 72 (seventeenth line) there are evidently misprints. Chapter IV. in this section might well be placed first in the book as it describes the normal and physiological conditions of the spine. We may here say that it would have been appropriate if the author had given us before each of the other sections a preface describing the normal and physiological processes that can be applied to the parts therein contained.

The whole subject of scoliosis is worked out in a manner that is incapable of improvement. Sections II. and IV. contain, respectively, the deformities of the neck, chest and upper extremities, and the deformities of the lower extremities. In these two sections the exposition is full and thorough throughout. It is in the treatment of his wounds—when it is described—that we cannot quite follow Mr. Tubby's intentions;

for instance, why does he "gently syringe" a wound after division of the femur for genu valgum? At its best the action can only be perfectly useless. Again after the performance of osteotomy for curved tibia, it is stated that "a counter opening for drainage may be made." It should be quite unnecessary.

We do not infer that Mr. Tubby has reason for attaching importance to these points and our only object in drawing attention to them is not to correct the author but to warn his readers to look upon them from the same point of view as we believe Mr. Tubby does himself.

Section V. treats fully the matter that can be included within the headings of ankylosis, congenital displacements, deformities resulting from cerebral and spinal paralysis and arthrodesis, and in a manner that is to be expected from the study of the first four sections of the book. The volume is profusely illustrated with plates, photographs and diagrams, most of which are original and are a great addition to this really valuable treatise.

HYDE ON THE CAUSES AND TREATMENT OF RHEUMATOID ARTHRITIS.[1]

THERE is never any doubt as to what Dr. Samuel Hyde means in the eighty lucidly and well written pages of his book upon "The Causes and Treatment of Rheumatoid Arthritis." The little work places before the reader an independent and experienced survey of the disease it describes. It is impossible to experience any other feeling than admiration for Dr. Hyde's endeavour to view the etiology and treatment of the malady from an unbiassed standpoint, and we therefore welcome this result of a thoughtful and thorough investigation of rheumatoid arthritis. The book is divided into the Cause and Treatment, but between the two are placed two short chapters that deal with its morbid anatomy and pathology.

Dr. Hyde discusses all the possible causes that have been adduced for this disease, and submits a new theory of his own, "he is inclined to the view that rheumatoid arthritis is a disease of disturbed internal secretions." We think Dr. Hyde himself will agree that in our present state of ignorance with regard to the etiology of this disease we can only be hypothetical in our definition, and therefore we may be justified in hiding our want of knowledge under so good, broad, and comprehensive a description as that which he submits to

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[1] The Causes and Treatment of Rheumatoid Arthritis. By Samuel Hyde, M.D. 96 pp. London: John Bale and Sons, 1896. (Price 3s. 6d.)

our notice. It covers a multitude of possible causes, for the nerve, blood, tissue, and even the bacterial origins may, with some fine adjustment, find umbrage beneath its extensive and elastic meaning. In fact, whatever is eventually considered to be the real cause of this disease, Dr. Hyde will always be able to point with pride to its provisional and tentative definition as given by himself.

Perhaps Dr. Hyde is not so happy in his description where he tries to wreck Dr. Archibald Garrod's definition upon page 4. We think that the word "recognisable" in Dr. Garrod's definition places that author in a correct and logical position with regard to Dr. Hyde's own views. Again, upon page 11, the author rather objects to Mr. Tubby's description of a certain case as being one of "traumatic osteo-arthritis." Dr. Hyde views the same case as being "a trophoneurosis of the joint due to a general neurotic temperament, which was determined to this special joint by the injury referred to." Without laying too much stress upon the point we think that "traumatic osteo-arthritis" is more concise than, and capable of conveying as much meaning as the longer sentence.

As stated above, there is a passing allusion to the anatomical changes that occur in bone cartilage, synovial membrane and ligaments, and it helps the author to emphasise the point to which he attaches so much importance when he says that sufficient significance is not placed upon the fact that in this disease there are other excreting sources affected besides those of synovial and bursal origins. It is for the latter reason that some surgeons of the present day prefer the name of osteo-arthritis, and we rather wonder at Dr. Hyde's preference for the name of rheumatoid arthritis, and our wonderment is not subdued when Dr. Hyde most fully and emphatically denies any causal connection between that disease and rheumatism or gout. All the views of all the authors that are quoted have a very careful and fair exponent in Dr. Hyde.

The last portion of work is, we think, of more value than the first, for it deals exhaustively with the treatment of the disease, upon which the author is evidently an authority. The effect of drugs, diet and clothing are elaborately reviewed, and the results of massage, and active and passive movements are rightly valued. As an *obiter dictum* we may say no allusion is made to efficient surgical interference. The last chapter in the volume upon the "Use of Animal Extracts in Rheumatoid Arthritis," is the most original and suggestive reading of the work. In conclusion we venture to hope that Dr. Hyde will keep the profession informed of the results of the experimental side of his treatment.

DOYNE ON THE EYE.[1]

WHETHER small books on special subjects are helpful to general practitioners is a matter of opinion. But Mr. Doyne has succeeded in compressing into a small compass a number of valuable hints and facts concerning the more common diseases of the eye, and his work, therefore, should prove to be of much use to those who have not especially studied this department of practice. A detailed criticism of this small work is scarcely called for, inasmuch as its title fully expresses its scope and aims, while the treatment and advice recommended can be thoroughly endorsed, emanating as they do from one who for many years has made a special study of diseases of the eye. We have, therefore, pleasure in cordially recommending Mr. Doyne's book as a small, helpful guide upon this special subject.

THE LIBRARY OF THE WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

BOOKS RECENTLY RECEIVED.

Presented by THE AUTHORS.

Cycling as a Cause of Heart Disease, by George Herschel, M.D. London: Bailliere, Tindall and Cox, 1896.

Curvature of the Spine, Fourth Edition, by Noble Smith, F.R.C.S.Edin., 1896.

The Enlarged Cirrhotic Liver. By Arthur Foxwell, M.A., M.D., F.R.C.P. Birmingham: Cornish Brothers [no date].

Skiascopy and its Practical Application to the Study of Refraction. By Edward Jackson, A.M., M.D. Second Edition. Philadelphia: The Edwards and Docker Co., 1896.

Deformities; a Treatise on Orthopædic Surgery, intended for Practitioners and Advanced Students. By A. H. Tubby, M.S., F.R.C.S.Eng. Illustrated with 15 plates and 302 figures. London: Macmillan and Co. Limited, 1896.

Presented by Mr. PERCY DUNN.

The Truth about Vaccination, by Ernest Hart, D.C.L. Second Edition, 1895.

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[1] "Notes on the More Common Diseases of the Eye," by Robert W. Doyne, F.R.C.S., Surgeon to the Oxford Eye Hospital, &c. London: H. K. Lewis, 1896.

The Medical School Calendar and Guide to Students for Scotland, 1896-97.
Official Handbook of Spas, Watering Places and Health Resorts, by H. C. Tiebel, M.D.
Calendar of the Apothecaries Society of London, 1896-97.
Cottage Sanitation in Rural Districts, by H. M. Wilson, M.D., B.S.C. Second Edition, 1896.
Various Papers on Cancer, by Herbert Snow, M.D., 1895.
The Middlesex Hospital Reports, 1894.
Notes on the more Common Diseases of the Eye. By R. W. Doyne, F.R.C.S., 1896.

Presented by Dr. S. D. CLIPPINGDALE, F.R.C.S.

Transactions of the British Balneological and Climatological Society, vol. i., 1896.
Vols. 1, 2 and 3 of the West London Medico-Chirurgical Society Transactions (1882-1888).
Artificial Feeding and Food Disorders of Infants, Dr. Cheadle, 1889.

Presented by Mr. C. B. KEETLEY.

The Transactions of the British Orthopædic Society, vol. i., (1896).
Flügel's Dictionary of the German and English Languages.
The Liverpool Medico-Chirurgical Journal, 1885 and 1886.

Presented by THE PUBLISHERS.

Lectures on Renal and Urinary Diseases. By Robert Saundby, M.D.Edin., F.R.C.P. Second Edition, with numerous illustrations. Bristol: John Wright and Co., 1896.

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The number of bound volumes now on our shelves amounts to about five hundred; and we have many unbound volumes of journals, and American and foreign publications in paper covers. Our book cases, including the two presented to us a year ago by Messrs. Chamberlan Bros. are full, and it has, therefore, become necessary to arrange for more. As I said in the October number of the JOURNAL, the various series we possess of the *Lancet*, the *British Medical Journal*, and the Transactions of various London Societies, form, if used together with Neale's invaluable Digest and its new appendix, which we possess, a magnificent collection of works of reference and source of information on almost every subject.

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Medical Press and Circular.
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The American Journal of the Medical Sciences.
The London Medical Record.
The various Journals on our "Exchange" List.
Hospital Reports (Guy's, St. Thomas's, St. George's, or any other).
Centralblatt für Chirurgie.
Centralblatt für Medizin.
Revue de Medicine.
Revue de Chirurgie.
Brain, Mind, Sanitary Record.
Public Health and other special Journals; and of the *Lancet* from 1873 to 1887, also for 1889, 1895 and 1896, as well as the volumes for 1894, 1895 and 1896 of the *British Medical Journal*.

The *exchanges* of our JOURNAL are accumulating a number of valuable but unbound volumes of other journals.

The problem must sooner or later be faced, of how to carry on our library and develop it in a thorough-going way. No one can doubt but that there is room for a medical library and reading-room, as a modest local copy of the great institution known as the Royal Medical and Chirurgical Society, which is four miles away, and the subscription to which is three guineas per annum (six guineas the first year). The object indicated cannot be attained on our ordinary five-shilling subscription. Probably the best plan would be that of a special library subscription of five shillings, payable by those members who wish to use the library. The hospital will no doubt be very glad to find a lodging for the books as long as we desire it; but ultimately a paid librarian will be required, so that the books, reading-room and writing-room may be accessible for a long period every day.

In plain words, the experience of provincial towns shows that a library like ours tends to develop into a Medical Institute as, for example, those of Birmingham and of Norwich. Such a project may look, at first sight, like an ambitious and expensive dream; but when fairly tackled and started, usually turns out very feasible, and if managed in a business-like and careful way, to a great extent self-supporting.

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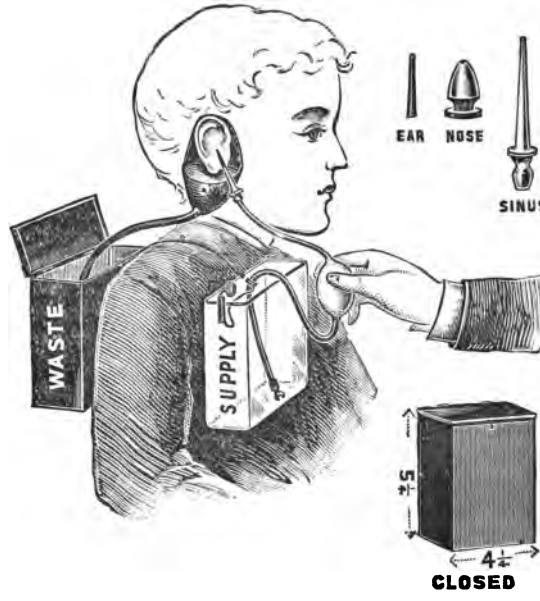
POST-GRADUATE TUITION IN LONDON.

Owing to extreme pressure on our space the report on the Post-Graduate Tuition in London for the current quarter is unavoidably omitted.—[ED.]

NOTES ON NEW PREPARATIONS, &c.

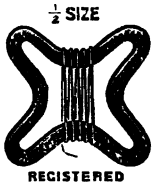
Twin Tank Ear Syringe.—Messrs. Reynolds & Branson have made this apparatus at the suggestion of Mr. J. J. Jackson, L.R.C.P. The accompanying drawing explains its use.



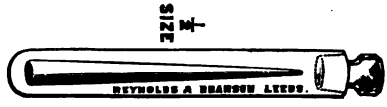
Its chief advantages are: That the waste must go into its receiver, and not down the patient's neck and clothes; the operator has both hands at liberty, and the patient can sit in an easy instead of a constrained position — in dealing with children this is most advantageous; the appliance is most compact and more portable than what we have had in use heretofore, the whole fitting as it does into the metal tank.

Messrs. Reynolds & Branson have also sent us their "New Glass Ligature Reel." Solid reels have the disadvantage when in use of requiring prolonged boiling to sterilise the deeper layers of the silk. At the suggestion of a surgeon this

one is made out of rod glass bent into the shape of a Maltese cross, so that the innermost layers of silk can be easily permeated by the boiling water in the process of sterilising. It is made in glass of various colours, so that the different sizes of silk may be easily distinguished. The glass is toughened by the boiling, and does not easily break.

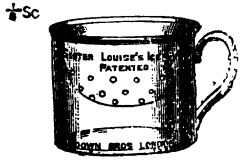


Messrs. Reynolds & Branson have sent us Herbert Robson's Aseptic Membrane Perforator, which is made of celluloid, or if desired, of glass or vulcanite; it is kept in a 1 in 1,000 solution of perchloride of mercury in a little glass-stoppered bottle without



collar. It is intended as a substitute for a hair pin in perforating the membranes, and is certainly more cleanly.

Sister Louise's Ice Cup (patented).—Messrs. Down Brothers have sent us a specimen of this Ice Cup, which offers several advantages in use for both nurse and patient. The old method of keeping the ice suspended on flannel or lint for purposes of drainage often caused fluff or hairs to adhere to the ice, and a certain amount of time must be taken up in tying the covering on a basin or cup, while also the edges are apt to drip. All this is avoided by the perfect drainage and cleanliness secured by the improved ice cup. It is made in earthenware for hospital use, and in glass of various colours for private nursing.—Sole makers, Down Bros., 21, St. Thomas's Street, Borough, London, S.E.



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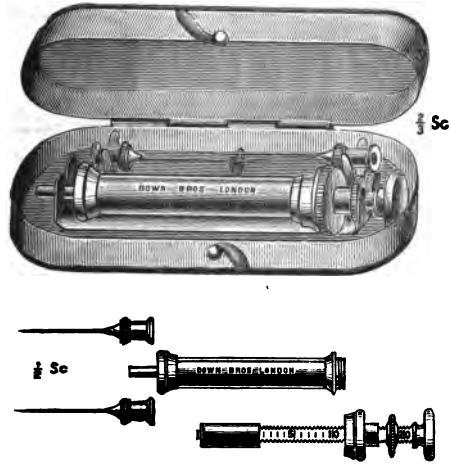
with vaseline. The metal barrel, too, is not liable to breakage, and can be boiled without fear of detaching the mounts. The



syringe is supplied with either steel or platinum iridium needles, and put up in a neat metal case.

Messrs. Burroughs, Wellcome & Co. have sent us a new tabloid prepared according to the following formula:—

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Messrs. Burroughs & Wellcome have sent us samples of **Residum Rubrum "Tabloids."** These "tabloids," prepared from the carefully-dried red residue of venous or arterial blood, have been under trial for some time in the treatment of osteo-arthritis and other diseases in which there is an absence in the patient's blood of the normal secretions of the various

ductless glands. After the usual treatment has proved ineffectual, Residum Rubrum "Tabloids," prepared from venous blood, may be administered with beneficial effect. They have been given in doses of twelve 5-grain "tabloids," taken during the twenty-four hours.

Hæmatic Hypophosphites. Messrs. Parke, Davis & Co.—This preparation, which contains hypophosphites of potassium, manganese, strychnine, iron and quinine, is one of the best methods of administering these drugs. The exact constitution of the preparation is printed on the label, so, though a special preparation, it is not in any way a secret remedy. It is pleasant to the taste, and is a good tonic.

Euthymol Tooth Paste. Messrs. Parke, Davis & Co.—This paste is made from euthymol, which is a mixture of oil of eucalyptus, gaultheria, boric acid, menthol and thymol. While having strong antiseptic properties, it is unirritating and non-poisonous, so it is specially suited for a preparation for the teeth. It imparts a pleasant odour to the breath, and a very small quantity need be used at each application.

Notes and News.

THE members of the Society are requested to take note that the January meeting will be held on Friday, January 8, instead of on the 1st—New Year's Day—as printed on the card.

THE Cavendish Lodge, of which mention has more than once been made in "Notes and News," was duly consecrated on October 26, and the ceremony was most impressively performed by Grand Secretary Letchworth, together with the other officers of Grand Lodge in attendance. The proceedings took place at the Freemasons' Hall, and in addition to the members of the Lodge, many visitors were present. The following is the list of officers for the year 1896-1897. W. M., Bro. Fred. Lawrance, P.A.G.D.C.; S.W., Bro. P. S. Abraham; J.D., Bro. A. Symons Eccles; Treasurer, Bro. Herbert Menzies; Secretary, Bro. W. H. Causton, P.M.; S.D., Bro. J. D. Mortimer; J.D., Bro. L. A. Bidwell; I.G., Bro. Percy Dunn; D.C., Bro. Richard Lake; Stewards: Bros. Maitland Coffin and George Cathcart; Tyler, Bro. F.

Madden. At the banquet which followed many congratulatory speeches were made, and the wishes for the prosperity and success of Lodge 2620 were duly received with masonic honours by the large company present.

THE first ordinary meeting of the Cavendish Lodge was held at the Freemasons' Hall on Wednesday, November 18, at which the following were elected as joining members, viz., Bros. Charles Handfield-Jones, C. B. Keetley, Charles Wells, George Shuter; Rickard W. Lloyd, and George Alfred Buckmaster were the first initiates. At the second ordinary meeting, on December 18, the initiates were: V. A. E. Corbould and F. J. McCann.

THE policy of changing from time to time the *menu* of the Society's work is undeniably expedient. The interest in the monthly meetings is apt to suffer somewhat when the ordinary programme of papers is rigidly adhered to. The council, therefore, are to be congratulated upon having decided to organise a discussion upon a special subject for the February meeting. The subject in question will be "The menopause," to be introduced by Dr. Amand Routh. The probability is that the attendance at the meeting will prove to be a very large one, and that many members will put in an appearance for the purpose of taking part in the discussion. It would doubtless assist matters very much in this regard were an abstract of the introductory remarks to be distributed among the members prior to the meeting. But, without any reference to the present case, experience has taught the officers of the Society that nothing is more difficult than to prevail upon the authors of papers to make an abstract of them before the communications are due. Owing to lack of opportunity many such papers are probably only written within a few hours of their being read. Under these circumstances, therefore, it would be impossible for the author to furnish abstracts in time for issue to the members.

NEVERTHELESS we believe that a rule exists in the Society to the effect that abstracts of papers shall be furnished to the Honorary Secretaries at least eight days before the meetings are held. But we have never heard of any one conforming to this rule, and no penalty is attached to its infringement. Had, however, a fine been exacted in all cases in which it had been broken, the Society would now undoubtedly be in the position to finance a weekly journal—instead of a quarterly one—out of the proceeds.

THE Editor is wishful to draw attention to one or two details in connection with the Reports of the meetings. In the first place he is especially desirous of making these reports as perfect and as complete as possible. In carrying out this object the members of the Society can render him much assistance : (1) by giving a careful report of their speeches, *written in the first person*, to the Junior Honorary Secretary for the time being ; (2) by furnishing full notes of the clinical cases which they show ; and (3) by handing in their papers, ready for publication, after they have been read. By attention to these details the work of the Editor would be much lightened, as well as that of the Junior Secretary, while at the same time the value of the Reports would be increased.

THE Editor desires also to point out that he will always be glad to receive the reports of clinical cases from members of the Society, for insertion in the " Mirror of Practice." There are probably a very large number of the members who have the notes of interesting cases which are worthy of being recorded.

WE are asked to announce that the second edition of Dr. J. B. Ball's book on " Diseases of the Nose and Pharynx," advertised in the last numbers of the JOURNAL, is out of print. A third edition is being prepared, and will be ready in the course of two months.

THE late Sir W. B. Richardson was well-known to many members of the Society. Upon the last occasion that the Annual Dinner was held at the Star and Garter, Richmond—that is to say in 1886—he was one of the Society's guests. The Society has made marvellous advances since those " Star and Garter " days. The idea of dining at Richmond was that it afforded the members an excellent opportunity once a year of seeing something of the country. The attraction was held out that the lovely view from the terrace of the hotel could be revelled in and made use of as a sort of appetiser before the dinner. But nothing was seen of the terrace after the festive repast had concluded, not because the members had then become incapable of appreciating its advantages, but mainly on account of the urgency which existed to catch the last train to London. Sir Benjamin, upon the occasion in question, probably inspired by the beautiful scenery which he had just viewed from the terrace, made an interesting, somewhat poetic, speech, upon the methods and means adopted by Nature of making the groundwork of scenery which, with

man's assistance, afterwards came to be famous for loveliness.

AN incident has occurred to one of our members, which claims some mention in "Notes and News." We allude to the marriage of our colleague, the Editorial Secretary. Mr. L. A. Bidwell, on October 28 last, was married to the eldest daughter of Major Roper Partington. A large concourse of friends assembled to witness the ceremony. And all of them took the opportunity afterwards to drink to the health of himself and his bride. The JOURNAL is largely indebted to its Editorial Secretary, and so, of course is the Society, for the work and time which he has devoted to the management of the advertisement and business departments.

THE West London Hospital has received the sum of £150 from the Countess of Ilchester, being part of the proceeds from the Exhibition held in connection with the Ladies' Kennel Club at Holland House last summer.

SIR JOHN WILLIAMS has accepted the invitation of the Council to deliver the next Cavendish Lecture, and the date fixed upon for the same is June 25, 1897.

MR. BERNARD QUARITCH, of Piccadilly, a short time ago sent us a copy of his latest catalogue of "Rare and valuable books." In glancing through the pages we came to a long list of books classified under the head of "Ophthalmy," &c. Among the various publications announced was one to which special reference may be made. Lot 533 was as follows: "West London Medico-Chirurgical Society: Proceedings, 1892-94, edited by J. H. Menzies and A. H. W. Clemow; 8vo, *cloth*, 3s. 6d." After this, all the members of the Society should be very careful to preserve the volumes of the Proceedings of which they are the possessors. It may now be safely assumed that each volume is the nucleus of a "rare and valuable book," and the time may come when each complete set will attain to the honour of being kept in a glass case under lock and key, by enthusiastic bibliophiles, who know a good thing when they have it. P. D.

Binding the Four Numbers of the Journal for 1896.—Arrangements have been made for binding the first volume of the JOURNAL. The four numbers can be bound together in a neat cloth case, to correspond with the old "Transactions," for one

shilling and sixpence, on application to Messrs. J. Bale and Sons, 85-89, Great Titchfield Street, W.

Most of the old numbers are still in print, and can be obtained from the Editorial Secretary, 59, Wimpole Street, W., for half price (9d.).

Readers of the JOURNAL, when writing to advertisers, are requested to mention the JOURNAL.

INDICATIONS FOR THE INDUCTION OF ABORTION.—Dr. Jeffé (*Medicinische Neuigkeiten*, No. 45, 1894), after a study of the literature of the last ten years, fixes the indication for inducing abortion as follows: Absolute indications—1. Uncontrollable vomiting of pregnancy. 2. Incarceration of the gravid uterus. 3. Obstruction of the pelvic outlet by tumours or exudates. 4. Progressive and pernicious anæmia. 5. Grave chlorosis. Relative indications—1. Great contraction of the pelvis with the conjugata vera below five centimetres. 2. Pulmonary emphysema with signs of degeneration of the heart. 3. Nephritis, especially with eclampsia. 4. Chronic heart disease. 5. Other general diseases of the mother which would jeopardize her life at that time of delivery. The author holds that a conjugate diameter of six centimetres and advanced pulmonary tuberculosis should not be regarded as indications for abortion, as it is not just to sacrifice a future life for one that is "certainly lost."

THE PREVENTION OF HERNIA AFTER LAPAROTOMY.—In a discussion at the Congress of the Gesellschaft für Geburtshilfe and Gynäkologie in Vienna, Winter stated that a systematic examination of the frequency of hernia after laparotomy at his clinic was: in 1889, 30 per cent.; in 1890, 29 per cent.; and in 1891, 23 per cent. While the first necessity in the prevention of these herniæ is primary union of the abdominal wound, it is also important to suture the fascia exactly instead of including all layers in one suture. He employed catgut sutures. With this improved technique, the herniæ for 1894 were reduced to 8 per cent., and among these only the smallest size was observed. He dressed the wound with collodion, and dispensed with the binder. Zweifel, Winckel, and Chrobak all used the same three-tier suture with good result. Dührssen and Martin still favoured the single suture, Müller and Ziegenspeck used the three-tier suture, but avoided the linea alba, incising through the rectus muscle.—*Wien kl. Rundschau*, 1895, p. 569.

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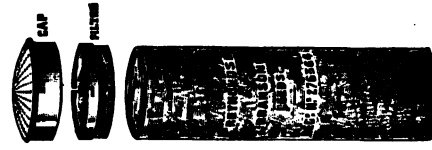

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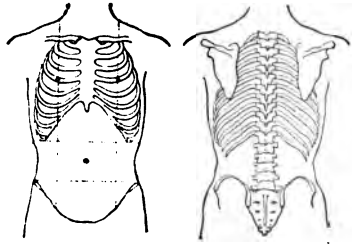

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NOTICE.—All communications relating to the Literary part of this Journal, Books for Review and Exchanges should be addressed to the Editor, Mr. PERCY DUNN, 54, Wimpole Street, Cavendish Square, W. Applications for Copies of the JOURNAL, communications respecting Advertisements, and Instruments, Pharmaceutical Preparations, &c., intended for notice, should be forwarded to the Editorial Secretary, Mr. L. A. BIDWELL 59, Wimpole Street, Cavendish Square, W.

THE

West London Medical Journal.

Published Quarterly under the auspices of the West London Medico-Chirurgical Society.

Original Communications.

THE MENOPAUSE, VIEWED FROM THE GYNÆCOLOGICAL STANDPOINT.[1]

By Amand Routh, M.D., B.S., M.R.C.P.

Patients suffering from disturbance at or about the period of the menopause come most frequently under the notice of the general physician, for the symptoms are usually both vague and multiple, but if the nervous or the gynæcological symptoms predominate, as they often do, the patient will consult a specialist in one or other of these departments of medicine.

I have been asked to open a discussion to-night from the gynæcological aspect, and propose to do so under two headings: (1) Organic gynæcological lesions which may especially affect women at the menopause; (2) Functional pelvic disorders which are superadded to other more general phenomena, all mainly hyper-æsthetic in type.

I may at once say that I do not propose to discuss the psychicial aspects of the menopause. That view of the subject

[1] For the discussion upon this paper see page 100.

will be discussed by Mr. Tuke, whose experience is not to be excelled. It is undoubtedly a fact, however, that the co-existence of the characteristic mental depression or delusions of a melancholic type, so common at this age, tend to make the treatment of any functional or organic affection much less successful than in cases where the hope and confidence of the patient are co-operating with the measures adopted.

(1) *Organic Affections of the Menopause.*

A woman's life may be divided into three periods: (*a*) before puberty; (*b*) between puberty and the menopause; (*c*) after the menopause.

We are here concerned with the beginning of the third period of life—the beginning of the period of diminished sexual activity, with a tendency to retrograde changes of an atrophic character in the generative organs, often preceded by a period of hyper-activity of those organs which are about to lose their function.

For the moment I wish to speak of some local vulvar and intra-pelvic states, which are most often associated with the menopause, ignoring the peculiar mental and nervous state of the patient which aggravate greatly the symptoms of those local conditions.

(*a*) The vulva—to take the external organs of generation first—partakes of this process; its adipose tissue gets gradually absorbed and its glands cease to actively secrete until, when senility arrives, the parts may be quite dry and shrivelled. Towards the end of menstrual life a woman is inclined to get stout, and the folds of the skin are apt to get red and eczematous from irritative secretions, and the vulva margins partake of this tendency. One of the commonest of the vulvar troubles at the menopause is pruritus pudendi, which is, of course, a symptom, not a disease.

Pruritus pudendi is a symptom of a distressing character, due to a large variety of causes. It may be a pure neurosis. It may be reflex, as in early carcinoma cervicis, or with mucous polypus, or prolapsed ovary. It may accompany kraurosis vulvæ and rashes of all sorts, especially eczema; or be due to dirt, ascarides, pediculi, or other less evident parasites; to vascular urethral caruncle or vulvar glandular swellings; to

irritative vaginal discharges, as in advanced cancer of uterus, or to irritating urine, as in vesico-vaginal fistula, chronic cystitis, acidity, gout or diabetes. A pruritus at this age, with a coppery or purple rawness of the vulva, is often the first evidence of diabetes, and is usually associated with gout, and is, therefore, a less serious form of diabetes than the early non-senile and non-gouty form of younger women, in whom this local evidence is not nearly so common.

I have mentioned kraurosis vulvæ as being one of the causes of pruritus of the menopause. This is an atrophic change associated sometimes with adhesive vaginitis. It is accompanied by very severe pruritis, and the skin and mucous membrane, perhaps as far back as the anus, have a dull or glistening white appearance, due to degeneration of the superficial and deep epithelium cells, which here and there become detached, leaving shallow irritable ulcers, which greatly add to the discomfort of the patient. Kraurosis is usually associated with a tendency to contraction of the vaginal orifice, with a liability to tear and split if coitus be attempted.

Kraurosis vulvæ is best treated at first with a half-strength unguentum hydrarg., with the addition of some suitable agent for co-existing ulceration or pruritus. Great improvement follows this, and if it be used freely a cure will ensue, at all events temporarily. I recall the case of a midwife in whom an ointment of

℞ Unguent. hydrarg. ... ... ʒi.
Unguent. plumbi ... ... ʒi.
Ol. menth. pip. ... ... ʒi.

Fiat unguent.

had been applied advantageously in small quantities twice daily for two months, and the patient being dissatisfied with the slowness of the cure determined to hurry matters by rubbing in the ointment several times a day. In ten days she was salivated and lost several teeth, but the vulva became free from all discomfort, looking pink and supple, and, indeed, quite healthy. In six weeks, however, the kraurosis began to recur and was with difficulty kept under control.

In cases where palliative treatment fails, the mucous membrane may be dissected off, but I have found very good results from scraping with a sharp-pronged fork [shown], and subsequent weak mercurial and lead inunction. At the same time the contracted vaginal orifice may be opened up by incisions.

In diabetic or gouty pruritus, the well-known Lassar's paste may be rubbed in, while suitable internal remedies are taken.

℞ Acidi salicylici ... ... gr. xx.
Zinci oxydi
Pulvi amyli ... ... āā ʒiv.
Vaselini alb. ... ... ʒii.

Fiat pasta.

In all cases treatment must be directed to the removal of the cause, but local palliative treatment must, meanwhile, be also adopted. These local applications are not very satisfactory, and may not continue to give relief even if they act like a charm at first. About the best local palliative application is a teaspoonful of the following powder in a pint of water.

℞ Sodii biboratis ... ... ʒiii.
Ol. menth. pip. ... ... ʒii.

Fiat pulv.

This sometimes produces a feeling of coldness or numbness which is not appreciated. Other local applications which are useful are the following:—cocaine ointment (gr. viii. ad. ʒi.); a lead or zinc lotion with hydrocyanic acid, menthol and olive oil (ʒi. ad. ʒi.) or aqua menth. pip., warmed.

In pruritus without obvious origin, corrosive sublimate solution (1 in 2000) often affords rapid relief by destroying some undiscoverable parasites, and it is a good plan to give phenacetin, as advocated by Sir John Williams, or salicylate of soda, internally at the same time. In all forms of pruritus warm baths are soothing. One of the best is equal parts of milk and barley water, with borax (ʒi. ad. Oi.), or a bath of water and liquor carbonis detergens (ʒi. to gallon). If the pruritus be reflex or neurotic, valerianate of zinc, phenacetin, or the bromides are useful, and a course of baths at Kreutznach or Woodhall Spa will hasten the cure in cases of gout or acidity.

Owing to atrophy of the vulva and stenosis of its gland ducts the glands of Bartholini and other glands may become cystic, and may need to be shelled out, and the wound encouraged to heal by first intention, by pressure and buried purse-string sutures. If the cyst be merely incised it will take three weeks to granulate up.

Vascular caruncle is common at the menopause and may be very painful, but is often less vascular and less painful than

at an earlier age. It should be removed deeply by the actual cautery.

Epithelioma is fairly common on the vulva at this age, but is more frequent ten years later. Its treatment is prompt and free removal.

It is impossible to allude to displacements of the vagina or uterus in such a short paper, but these are apt to be very troublesome at the age under consideration.

(*b*) *Intra-pelvic organic affections.*—At the menopause the uterus ceases to have its menstrual cycles, and both ovaries and uterus gradually atrophy, and in the course of two or three years become entirely functionless. It is now known that, apart from the ordinary functions of the ovaries, there is what is called an "internal secretion" of those glands, which alters the blood passing through them, and thus affects the whole constitution. This constitutional alteration is well seen in the suddenly induced menopause after the removal of normal ovaries for arresting the growth of fibroids, and explains many of the more slowly produced characteristics of the climacteric. If the patient has suffered from fibroids, the arrival of the menopause is delayed for four or five years, but then, unless one of the fibroids have become submucous or polypoid, menstruation ceases and the fibroids atrophy, or degenerate harmlessly by a calcareous deposition. Sometimes, spite of the menopause, a fibroid of the soft, non-encapsuled variety, continues growing.

The hæmorrhages of the menopause.—One of the commonest troubles at or about the menopause is hæmorrhage. Irregular losses should at that time always be regarded with suspicion, especially if they come on after a few months' amenorrhœa. They are, however, almost as likely to be due to organic disease if they occur between regular menstrual periods at this age, and in all cases local examination should be proposed, lest what was at first, for instance, a localised epithelioma, should become too far advanced for surgical treatment. Uterine hæmorrhage at the menopause may be of constitutional origin, such as alcoholism, and is then due either to hepatic disease, or to a granular endometritis, which is so often associated with alcoholism as to be probably due to it.

Chronic heart or liver disease may also tend to such irregular hæmorrhages, and so may early myxœdema, but as local

disease may co-exist, a local examination should still be made. Local causes of hæmorrhage at this age are of vaginal or uterine origin. Vaginal examination with the finger enables one to ascertain the existence of mucous polypus of the cervix, a protruding fibroid polypus of the uterus, or malignant disease of the vagina or cervix. The loss may be found to come from an ulcerated inverted vagina with a procidented uterus, or to be due to foreign bodies; or it may be due to that form of vaginitis common at and after the menopause, called "ulcerative adhesive vaginitis," which is evidenced by the vagina being narrowed and irregularly bound down, and thrown into folds or pockets by mucous or submucous adhesions. Discharge is often offensive and blood-stained, and these symptoms, with a cachexia which is usually present from septic absorption, may closely simulate malignant disease, which may supervene at a later age, especially among the adhesions round the cervix.

The *treatment* of these vaginal sources of hæmorrhage is simple. The ulcerative adhesive vaginitis is best treated by breaking down the adhesions, touching the resulting raw surfaces with nitrate of silver, keeping the vaginal surfaces apart by loosely packing it with antiseptic gauze, and finally using borax and lead douches. In a week or ten days the vagina is well, though recurrence is not unlikely. Fibroid polypi, whether in vagina or uterus, should be removed by cutting through the pedicle at its insertion into the uterus by scissors, or if preferred, by the wire *écraseur;* but a mucous polypus should be removed by twisting or by the cautery, as hæmorrhage would surely follow if it were snipped off with scissors, for it must be remembered that the muscular tissue of a fibroid polypus and its pedicle, and of the fundus uteri, retract, and so arrest hæmorrhage, whereas in a mucous polypus no such hæmostatic conditions are present.

If there is no vaginal or cervical explanation of the hæmorrhage, and the uterus is bimanually discovered to be large—verified may be by the sound—the uterus must be dilated to diagnose between granular or fungous endometritis, submucous fibroids, mucous or fibroid polypi, carcinoma or sarcoma of the body of the uterus. In small uteri, so-called atrophic endometritis may exist.

Some years ago I read a paper elsewhere in which I collated

a good many consecutive cases where hæmorrhages were due to intra-uterine causes, in which it had been necessary to dilate to introduce the finger, and I found that in 88 per cent. of those cases the actual cause of the hæmorrhage was a removable one.

Exploratory dilatation of the uterus by the rapid method under anæsthesia is infinitely safer and better than the slow and often dangerous dilatation by tents, and the whole process of dilatation and exploration can be done in less than half an hour. If the nurse puts a glycerine tampon into the vagina near the cervix two hours before the operation the cervix yields perfectly, because the glycerine causes the cervix to secrete freely, and a secreting cervix is a relaxed, distensible one. The introduction of even one's little finger into the uterus will enable the diagnosis to be made between fungous or other form of endometritis, polypus, or malignant disease; though if the smaller finger does not penetrate far enough, the index finger must be used.

The treatment of these conditions may be dismissed in few words. Fungous or granular endometritis require curetting, preferably by a flushing curette. The atrophic form of endometritis, where microscopically the scrapings show the epithelium to be squamous and scanty, the glands few, and often dilated into small cysts without outlet, is not cured by curetting, but is best treated by a series of applications of iodine, &c., on probes at a week's interval.

Malignant disease requires vaginal hysterectomy, unless contra-indicated by extension of the disease beyond the confines of the uterus. This operation is now performed almost without mortality, though the great majority get recurrence within two or three years. Still it should always be tried if it be a suitable case.

Drugs at the menopause are much less useful for the arrest of hæmorrhage than during active sexual life, owing to the fact that hæmorrhage at 45 or 50 is much more likely to be due to organic changes, and also because uterine muscle is not so active, and therefore not so easily influenced by ergot, hydrastis, &c., as earlier in life.

Diet should in all such cases be entirely non-alcoholic, and the bowels and liver must be carefully stimulated.

(2) *Functional Pelvic Disorders.*

Apart from organic diseases, which are so common at the menopause, there are many subjective phenomena referable to the pelvis which bring the patient to the gynæcologist. It is his duty to make a sufficient pelvic examination; to treat local disease if present; but if this can be excluded, to so assure the patient, thus taking her mind from a part of the body which is apt to become the subject of a morbid imagination.

I put on one side those cases of exaggerated sexual hyper-æsthesias which are often found at this period of life, and propose to speak of other local hyper-æsthesias simulating organic disease. These are mainly in organs which have been previously organically affected, and may in a sense be still slightly so affected; but local treatment seems to me to aggravate such cases unless definite local disease is found. They are really of the nature of a local neurosis, sometimes really painful, and then often neuralgic in type; sometimes more allied to pruritus; sometimes producing heat or burning sensations; or more rarely a cold, or even an icy sensation. One thing is particularly noticeable—if a patient has had chronic ovaritis, prolapsus uteri, or cystocele, or adhesions persisting after old peri- or para-metritis, it is a fairly certain prophecy—to be kept of course to oneself—that at this hyper-æsthetic period of life all symptoms will be more marked, though there will probably be less local evidence of disease.

If local disease be absent, or can be safely ignored, such cases should be treated by general measures, with, in some cases, local sedative applications such as baths or hot-water vaginal douches.

It is often noticed, as Dr. Head has shown, that portions of the surface of the body which are fed by the same sensory nerves as supply the viscera which are affected, are also hyper-æsthetic. If so, a blister over that area, or over the spinal process from which the nerves issue, and which is often found to be tender, will greatly facilitate recovery. The general symptoms of the patient, associated with her age and menstrual history, help one to determine the nature of the trouble. If she has flushings, vertical or occipital headaches, dyspepsia relieved by food, depression of spirits, globus, visceral or parietal pains of irregular distribution,

with a most voluble, though tangled, statement of real or imaginary troubles, one readily sees the neurotic aspect of the case, and the less local treatment is adopted, the better for the patient.

I wish to add a few words as to the "flushing" of the menopause. It is often spoken of slightingly, even disrespectfully, by those who do not so suffer; but if one watches a refined sensitive woman under the influence of this trouble, it is at once seen that her sufferings are very real, and that the prostration afterwards is very marked. I take the following account from a lady whom I have carefully watched on several occasions, and whose words are not at all an exaggeration of her real sensations.

The first sensation is a distinct but short feeling of cold, as if a warm fire would be very pleasant; then comes a sudden rush of blood all over the body, but especially to the head, where a bursting sensation is often felt. There is often a suffocating feeling with temporary difficulty of inspiration. The hands burn both subjectively and objectively, and the face shows marked evidence of the surface congestion, assuming sometimes an almost purple colour. There is at the same time much nervous tingling, throbbing of vessels, palpitation, and then, when the feeling of heat is at its height, and the oppression most marked, a sudden, and sometimes profuse, sweating ensues, and relief is afforded. The whole process may have taken only two or three minutes, and yet the patient may feel prostrate and depressed for another ten or fifteen minutes afterwards. Such attacks may come on during sleep, waking the patient up, and preventing further sleep for some time.

If these "flushings" are frequent, prostration is constantly present. I have heard ladies, who have lived in India, say that a "flushing" with its stages, is very like a concentrated attack of ague, compressed into a few moments.

These "flushings" are relieved by a menstrual flow, or by hæmorrhages from rectum or nostrils, &c., but are also relieved by the occurrence of menstrual molimina without actual loss, pointing rather to a nervous than to a vascular origin of the "flushings."

One of the most constant phenomena of the menopause, associated with these "flushings" is tachycardia, the pulse

keeping for months at 100 or 120, or more, often accompanied by breathlessness and sighing. The general treatment of all such functional neuroses is mainly purgative and sedative. Purgatives should as a rule be salines with an occasional dose of blue pill or calomel; the bromides with valerian and ammonia; and some warming carminative such as peppermint, cloves, or capsicum should be added.

The following is a good prescription to be taken when one of these nerve attacks occurs:—

℞ Ammon. bromidi	... ...	gr. vii. vel xv.
Tr. valerian ...	... ...	ʒ ½
Spir. chlorof. ...	... ...	♏ xx.
Spir. ammon. aromat.	...	♏ xxx.
Tr. Zingib. fort.	... ...	♏ v.
Aquam caryophyll. ad.	...	ʒi.

Fiat haustus. p. r. n.

Loin pain, with heat during micturition or frequency of the act, is often due to acidity and should then be treated with citrate of potash freely. It is astonishing how often symptoms of acidity and dyspepsia are present, and how the whole system is relieved when they are thus treated.

The most troublesome symptom to relieve is the tachycardia, which is uninfluenced by strychnia or arsenic, and even digitalis is almost useless. The bromides are certainly the best drugs to slow and steady the heart under these circumstances, but I expect to learn much from the discussion on this and other points. Much might be said as to diet. Suffice it now to say that alcohol and all richly made-up dishes are to be avoided. Exercise should be encouraged. Clothing should be warm, and flannel should be worn next to the skin, as the perspiration after the flushes is very apt to cause a woman to get a severe chill, if at the time in a draughty or cold place.

It need hardly be said that all these functional cases require much encouragement, and patients need to be assured that when the period of hyper-æsthesia is past, their after life will probably be one of greatly improved health and happiness.

THE PSYCHOLOGY OF THE MENOPAUSE.[1]

By C. M. Tuke, M.R.C.S.

In discussing the psychological aspects of the climacteric it will be well to be as practical as possible; I propose, therefore, to confine myself to the special point of the unsoundness of mind so often developed.

The literature of the subject is by no means extensive, but an interesting article appeared in the *Journal of Mental Science* in 1894, by Dr. Edwin Gosdall and Dr. Craig; and Dr. Savage had previously read a paper on the subject in 1893, before the Medical Society. The period between the ages of 40 and 50 is one of "stress," when the organs and functions developed in early life undergo involution, or, as it may be called, a process of "inverted puberty."

The neuroses seen show many gradations, from nervous irritability, with effects on the character and temper, to fully developed insanity, which has a tendency in a large proportion of cases to melancholia, or delusional insanity, less frequently to mental weakness, and rarely to general paralysis.

Speaking first of the slighter neuroses, I would mention those more common symptoms, such as flushings and fulness of the head, giddiness, sensations of heat and the like. These may be morbidly exaggerated till they come to be insanely interpreted, leading to the formation of false impressions, delusions and hallucinations. The process may be very gradual: ideas about electricity may be developed, or dread of impending evil, dirt, or contamination; the patient may describe herself as being "unlike her own self," or even as being "dead."

The change in the reproductive organs, and passing of sexual functions, leads in some to a morbid querulousness, in others to a jealousy, either of which may seriously disturb domestic peace. A sexual excitement sometimes is developed which overrides all control; depraved and vicious habits may show themselves, and dangerous false accusations may be made, which, though remarkably unpleasant, may have considerable medico-legal interest. Drunkenness has been noted

[1] For the discussion upon this paper see p. 100.

as being more common at this period of life among women than at any other, while the habit of taking drugs is not infrequent in all classes of society.

Some women are found constantly to change their lodgings, moving from place to place without obvious cause, being really impelled to do so by suspicions or delusions of persecution, which may, however, be carefully concealed. The advanced melancholia cases have frequently a suicidal tendency, for the depression is often associated with feelings of "unworthiness" or of self-accusation with harassing religious doubts and distress of mind. In the delusional form there is sometimes a basis of bodily disturbance on which a superstructure of delusions is raised. For example, with some gastro-intestinal derangement there are delusions of poison and refusal of food; cutaneous sensations with delusions of electricity and galvanic shocks; and uterine disturbance may co-exist with erotic symptoms, very often accompanied by delusions of a highly indecent character.

Hallucinations of the special senses are very frequently observed, especially that of hearing—in fact, auditory hallucinations should always be looked for.

Dr. Savage has spoken of the "deafness of the menopause," which has a marked influence on the mind. Remarking that deaf persons are apt to be suspicious that others are speaking of them, he says "he believes that there is a distinct group of cases in which the deafness and the suspicion arise at the same time, and together join in building up a form of neurosis which is pretty constant in its aspect and very unfavourable in its result."

Recovery from previously existing insanity is sometimes spoken of as being likely to occur at the menopause, but this, in my experience, seems rarely the case. It is possibly confined to cases of profound depression with no loss of mental power.

A growth of hair on the face may be observed in climacteric cases, but it is also seen at much earlier periods of life in other mental disorders.

The prognosis is not altogether unfavourable in asylum practice. Looking back at the case-book, and the last ten cases under the care of Dr. Seymour Tuke and myself, I find that five ultimately recovered after about two years. These

favourable cases were four of melancholia, and it is noticeable that there was in each of them an absence of heredity and of any organic disease, or of previous attacks.

Treatment in early stages is very important. Patients are sometimes too apt to concentrate attention on vague and obscure symptoms referred to the uterus. General treatment, rest, and change of air are here of value. When actual symptoms of insanity arise, it is often necessary to treat the case by removal from home, for the nature of the delusions, suspicions, and jealousies often demand separation from friends. The physical health requires constant attention, while the patience, perseverance and resources of the medical attendants and nurses are in some cases tried to the utmost, especially if there be refusal of food or suicidal tendency to overcome. Of pathology we can hardly expect to say much. German writers have, I believe, described the disease as a "premature senility," and an "atheromatous condition of blood-vessels" is suggested, but the fact remains, as I have pointed out, that happily we see many cases restored to mental and physical health.

SIX CASES OF STRANGULATED HERNIA IN INFANCY OR EARLY CHILDHOOD.[1]

By Stephen Paget, M.B., F.R.C.S.

These six cases all occurred in male children, and all at the West London Hospital. Three of them were 3 months old, one 7 months, one 1 year, and one between 2 and 3 years. All of them were cases of inguinal hernia; five on the right side, one on the left, and one of them a few weeks after operation on the right side was brought back to the hospital with strangulated inguinal hernia of the left side; this was reduced under chloroform without operation.

In one the hernia was of the congenital type; in one the character of the hernia could not be made out, as the tissues were already gangrenous. In the other four cases there was a

[1] For the discussion upon this paper see page 97.

distinct sac, not communicating with the tunica vaginalis. In three of the six cases the cæcum was in the sac.

Two of the infants died, and in one case the wound broke down a week after the operation. One of the two who died was a seven months' baby, 3 months old, and the thirteenth child in a very poor family; it had been brought to the hospital in the middle of a bitterly cold night, and four days after the operation it showed signs of acute bronchitis, and of this it died on the twelfth day. The other, also 3 months old, had the bowel already gangrenous and perforated at the time of operation. I made an artificial anus, and the infant did well for a month, but then began to waste, and died six weeks after the operation.

Strangulated hernia thus early in life is seldom seen. The two best accounts of it that I know are those by Mr. Howard Marsh, in the *St. Bartholomew's Hospital Reports* for 1874, and by M. Féré, in the *Revue de Chirurgie* for 1881. Both writers note the rarity of these cases. Mr. Marsh says of his own case: "I believe this is the only instance where an operation has been performed at the Hospital for Sick Children in the course of the last twenty-three years." It is, then, an odd chance that I should have had six cases in five years; and they may be worth bringing before this Society because they serve to show some points of difference between strangulated hernia in infancy and strangulated hernia in adult life.

(1) A male child, 2 years and 3 months old, was under my care in November, 1895, for a suppurating bruise on the forehead. He was, on admission, wearing a bandage for left inguinal hernia, but this was taken off by the House Surgeon, as no hernia was visible, and as the child was always quiet, had no cough, and was kept always in bed. One evening he was found to be in pain, with a large tense inguinal hernia of the left side. Chloroform was at once given, and taxis was tried for ten minutes without avail. The child vomited while under the chloroform. I saw him two hours later, taxis again failed; operation showed a sac so thin that great care was needed in opening it. There were only a few drops of clear fluid inside it; the bowel was congested and thickened, and at the seat of constriction it showed a pale dull patch. The hernia was of the congenital type. The return of the bowel, after division of the stricture, was assisted by holding up the

child's feet. The bowels acted on the third day, and the child did well.

(2) A male child, 7 months old, was admitted under me on May 3, 1895, with strangulated inguinal hernia of the right side. It was uncertain how long the bowel had been strangulated; the child had vomited five times before admission. The hernia was large, tense, without definite impulse; the skin over it was slightly œdematous. Chloroform was given, taxis was tried, but without avail. Operation showed the tissues outside the sac all matted together. At the point where the sac was opened there was not a drop of fluid, but there was a small quantity of clear serous fluid at the bottom of the sac. The bowel was slightly congested, rough here and there with lymph, and slightly bruised at the point of constriction. The stricture lay deep, and even after it was divided there was some difficulty in reducing the hernia. The bowels acted a few hours afterward, and for some days there was slight diarrhœa. A fortnight after leaving the hospital the child was brought back with strangulated hernia of the opposite side, the left inguinal region. The history of this second hernia was as follows: it was first noticed on May 27, when it suddenly appeared; it was put back several times that day without difficulty. On the 28th the child was measured for a truss, which was promised for the 29th but was not sent, and on the 30th the hernia came down again larger than before, and was not to be reduced. The child was lying on its back when the hernia came down—it had at the time a slight diarrhœa. It was brought at once to the hospital in pain, but not vomiting; the hernia was reduced under chloroform; the bowels acted next day, and the child did well.

(3) A male child, 1 year old, was admitted under me on January 27, 1891, with strangulated inguinal hernia of the right side. It was not known how long he had been subject to hernia. The bowel had been strangulated about four and twenty hours; the child had vomited repeatedly, but was not in pain, and was not collapsed. The hernia was large and tense; the scrotum was congested. Chloroform was given and taxis tried, without avail. The sac was found to be very thin, containing scarcely a drop of fluid; inside it were a coil of small intestine, a fringe of omentum, and a part of the

cæcum, which lay behind the small intestine. The small intestine looked healthy, save that it was marked at one point with a few punctiform hæmorrhages. I divided the stricture and returned the cæcum first, and the small intestine then ran back of itself. The bowels acted twice that same evening, and the child did well. Six days after the operation the hernia appeared again, but was easily reduced.

(4) A male child, 3 months old, was admitted under me on February 14, 1894, with strangulated inguinal hernia of the right side. The hernia had first been noticed a fortnight ago, but had then disappeared. The child had been well and the bowels had been acting properly up to five o'clock on the evening of admission; then the child, while in its perambulator, began crying, and its mother found the hernia "larger than it had ever been." The child was admitted at ten o'clock, having vomited three times; it did not seem to be in pain. There was a small right inguinal hernia, not very tense. Chloroform was given and taxis tried, without avail. Operation showed a very thin sac, containing about two teaspoonfuls of slightly blood-stained fluid, and a knuckle of small intestine; this was slightly congested, and had a rough patch on it, and at the seat of constriction was slightly bruised and inclined to bleed. There was some difficulty in returning the bowel, after division of the stricture, till the child's feet were held up; then it slipped back at once. The bowels acted that night, and there was slight diarrhœa for a day or two. On the seventh day the wound was dressed; it looked firmly healed, and the stitches—a continuous suture of fine silk—were not taken out. That same evening the wound suddenly gave way along its whole extent, and more than a foot of intestine escaped into the dressings. Mr. Lewis, the house surgeon, at once put the child under chloroform, cleansed the intestine, divided the stricture again, and returned the intestine. He then transfixed and tied the neck of the sac, but did not remove the sac, as it was closely adherent to the tissues round it. The operation was difficult and anxious, and the child more than once stopped breathing during it. The shock passed off in a few hours; the bowels acted thirty hours later. The day after the operation the pulse was 160, the temperature 102°; next day pulse 180, temperature 104°; slight diarrhœa and distension. These

troubles stopped in a few days; but then Mr. Lewis's sutures in their turn failed to hold. The edges of the wound slowly curled inward, like the lips of a wound in the scrotum, and failed to unite; slight suppuration occurred, and they had to be fomented for a few days. The child went home, with the wound soundly healed, on March 22, five weeks after admission. On May 11 it came back, with an abscess just under the scar; this was incised and packed with gauze. On July 10 it came back again, because the hernia had again begun to show itself, though Mr. Lewis had tied the neck of the sac. It was easily reduced, and a new truss was ordered for the child.

(5) A male child, 3 months old, was admitted under me on February 11, 1891, with strangulated inguinal hernia of the right side. It was brought to the hospital at three o'clock on a bitterly cold morning; it was a seven months' baby, and the thirteenth child in a poor family. The hernia had been strangulated twenty-four hours, and the child had vomited several times. Hot bath, chloroform, and taxis were tried without success. Operation showed a very thin sac, containing about a drachm of clear colourless fluid; inside it was the cæcum, slightly congested, with the vermiform appendix. They became somewhat contracted after a few minutes' exposure to the air; this contraction was especially marked in the appendix. The stricture was divided, the child was held up by the feet, and the bowel went slowly back. The bowels acted a few hours later, and the wound healed soundly, but on the fourth day the infant showed signs of acute bronchitis, and of this it died, on the twelfth day after the operation.

(6) A male child, 3 months old, was admitted under me on December 17, 1890, with strangulated inguinal hernia on the right side. The hernia was large and tense, and the scrotum was acutely inflamed. Under chloroform, after a few minutes' taxis, I reduced the hernia, but the scrotum remained much inflamed, and the testicle and the cord were greatly thickened. For ten days all went well; the vomiting stopped on the day after admission, the bowels acted freely, the infant took a quart of milk daily, and was gaining strength and weight. On the twelfth day there was more swelling of the scrotum; on the thirteenth still more swelling, and the child had been sick once; on the fourteenth the scrotum was tense,

emphysematous, resonant on percussion, and at one point thinned and gangrenous; the prepuce was œdematous, the penis was drawn sideways; the inguinal canal was occupied by a tense cylindrical swelling. Operation showed the cæcum, already gangrenous and perforated; no sac could be made out; the tunica vaginalis was full of fæces. I laid the bowel open freely, and fastened it in the wound. The infant did very well for a month; the cavity of the tunica vaginalis became closed by healthy granulations, the bowels acted twice a day through the wound, and there was no trouble from prolapse. At the end of the month the child began to lose weight, and died about six weeks after the operation.

Remarks.—I venture to call attention to the following points in these six cases:—

(1) In three of them the hernia seems to have become strangulated while the child was at rest, either in bed, or in its perambulator, or lying on its back.

(2) In two of them, though the bowel had not long been strangulated and was but slightly injured, yet the scrotum was already congested or inflamed.

(3) In three of them, after division of the stricture, reduction of the bowel was certainly made easier by holding up the child's feet, so that only its head and shoulders rested on the table.

(4) In more than one case the operation was made difficult by the extreme thinness of the sac—a mere film of membrane—and by the absence of fluid from it.

(5) In most of the cases the bowels acted within a few hours of the operation, and in two of them there was slight diarrhœa for a few days.

(6) I did not do a radical cure in these cases, being anxious not to prolong the operations and thinking that the tissues, in such very young children, would heal firmly without it; but the relapse of the hernia in case 3, and the breaking down of the wound in case 4, seem to show clearly that in all these cases we ought to tie the sac and close the ring.

(7) The breaking down of the wound in this fourth case is somewhat hard to understand. A whole week had passed since the operation; the stitches had not been touched, the wound had been dressed that morning, and then looked firmly healed. In the evening it broke down along its whole length,

its edges curling inward like the edges of a wound of the scrotum. I am having sections made of the skin over the inguinal canal in young children, to see if it contains unstriped muscular fibres like the tunica dartos, it is hard to see what else can have made the edges of the wound thus give way and turn inward.

(8) In the last case the hernia was certainly reduced when the child was admitted, for the bowels acted freely for ten days. The scrotum remained much thickened and inflamed, and thus the relapse of the hernia was not at once noticed.

Thus these six cases seem to show that there are some points of special interest in strangulated hernia in infants. It is not unlikely to occur while the infant is at rest, and in infants vomiting is so common that a strangulated hernia may easily be overlooked, as happened in three fatal cases among those collected from various sources by Mr. Marsh. The scrotum may be congested or inflamed very early, even though the bowel be but slightly damaged. Especial care is necessary in the operation on account of the extreme thinness of the sac and the very small quantity of fluid in it. The return of the bowel after division of the stricture may be helped by lifting the child's feet. The bowels are likely to act soon after the operation, and to be somewhat relaxed for a few days. In every case a radical cure should be made at the time of operation, unless the child is so collapsed that it is dangerous to prolong the operation even for a few minutes.

A PLEA FOR A MORE PRECISE CLASSIFICATION OF DISEASE.

By W. J. Tyson, M.D., F.R.C.S.

The time seems to me to be approaching, if it has not already come, when a more definite and diagnostic classification of diseases should be made.

The causes of diseases are becoming better known every day, and many that in the past have done duty, either under the head of "predisposing" or "exciting," must fall away and give place to others more precise and causative.

Until a few years ago a cold or a chill was thought to be the cause of nearly all inflammatory states in every part or organ of the body; it acted as a satisfying and comfortable explanation of all troubles alike to patients, their friends, and the doctor; it covered up an immense amount of ignorance, and spared need for further clinical research; but in these days of pathological and laboratorical examination, cold as an origin of disease must take a declining position. It is not denied here that it plays some part in disease, although at present it seems to be a mysterious one.

My subject is so large and vast in all its ramifications that I must take up, so to speak, one aspect of it, and my remarks will mainly be directed towards a plea for the attainment of a more precise clinical classification of disease.

The three general causes of disease given in our text books are classed under the heads of Traumatic, Chemical and Vital, the last including all infectious and contagious diseases. Under each head will be found a great number of diseases unlike in their qualities or symptoms, and I doubt very much if this method of classifying diseases has been of much service to the practical physician or surgeon. What is wanted is that the known causes of the disease should have a proportionate value put upon them, and again, that no prominent symptom should be classed as a disease if it is possible to put a causative or defining adjective in front of it.

I believe as our knowledge advances the so-called direct causes of disease will decrease in number, in other words, the traumatic and chemical causes will take the place more of what used to be called predisposing causes. Injuries to tissues, whether produced by traumatism or by chemical agents, place tissues and organs of our body in such resistless states that the various active bacterial agents have more or less full play; but this theme I will not pursue further, but will illustrate the meaning and project of my short paper by taking certain well-known diseases, and discuss their causes in some detail from a clinical standpoint.

To begin we will take pneumonia. Under this head is generally included what is termed acute croupous pneumonia, catarrhal or tubular pneumonia, and interstitial pneumonia. Formerly pneumonia practically meant only one form of the disease, viz., the sthenic form with all the well-known classical

symptoms and signs, as high fever, hot skin, quick pulse, flushed cheeks, coated tongue, great thirst, febrile urine, with dulness on percussion, bronchial breathing, bronchophony, &c., ending by crisis, and for which blood-letting was commonly done. I believe that this was the only form of pneumonia known to our forefathers, and when the word pneumonia was used it carried with it all those symptoms and signs that we now generally associate with acute croupous pneumonia, occurring for the most part in healthy young adults. If there is one disease more than another which seems to be caused by a chill or exposure to cold this is certainly the one; yet many cases come under our notice when no such origin can be traced.

I would advocate that if the word pneumonia be retained, standing alone without a qualifying adjective, that the acute croupous form should always be understood to exist. But to use the word indiscriminately for all sorts and conditions of inflammatory states of the lung is a misnomer, and leads to errors in diagnosis and treatment. The pneumonia occurring in influenza, known to all of you, is clinically distinct; it has its own history, its own peculiar features, runs a certain course, and cannot practically be considered apart from the original disease. It may be, and often is, the most important symptom of the influenza, but it is only one of the many results that may be met with in an attack of influenza.

Take again that form of pneumonia met with in alcoholic persons, the leading symptoms of which are: Moderate temperature, excessive expectoration, spreading of the inflammatory condition, great depression of the nervous system, low circulatory condition, &c.; or again, that infective or septic form of pneumonia, peculiarly well marked, after some attacks of erysipelas, which comes on perhaps days or even weeks after the original poison has passed away, characterised by small patches of lung affected, wandering in character, quickly appearing and afterwards disappearing, resistful to all treatment, fatal in prognosis; or again, that clinical form which occurs late in typhoid or typhus. The list might be extended, but I have said sufficient to indicate that each of the above are unlike in character, have a different origin, run a different course, and the line of treatment is not necessarily the same in each form.

The next disease I wish to say something about is peritonitis. It appears to be very questionable to my mind whether the word peritonitis should ever be used without some explanatory adjective accompanying it. Has anyone here ever seen a case of so-called simple peritonitis? All my life I have been looking out for such a thing, and so far have not succeeded in meeting one. The causes of peritonitis are after all comparatively few in number, and I doubt if "cold" can be reckoned as one among them.

In children, apart from tuberculosis and typhoid, peritonitis can almost invariably be traced to disease of the vermiform appendix. One has met with it in intussusception, and also very occasionally from strangulation of the gut in connection with Meckel's diverticulum. I have never seen infantile peritonitis from an infective cause nor from exposure to cold. Coming on to middle and later life one must add to the above a few more causes, such as propagation of inflammation from adjacent organs, viz., ulceration or perforation of the stomach or bowel, strangulation of the bowel, metritis, &c. New growths in the peritoneum, and almost lastly, peritonitis from injury to the peritoneum produced by accidents or from operative procedures. We have all seen exceptional cases of peritonitis, and I may mention here that somewhat rare condition, happening late in life, of falling of the splenic flexure of the colon upon itself, at first setting up a distended condition of the bowel, followed by constipation—this latter condition being the one for which medical advice is sought. The attacks are at first mild, gradually increase in frequency and in length, until ultimately a peritonitis and fatal obstruction closes the scene. Upon such a case I made a *post-mortem* a few months ago. Doubtless those cases would be benefited by elevation and massage, as recommended by Mr. Jonathan Hutchinson. Again, there are cases of peritonitis directly septic in origin, where pus escapes at once into the abdominal cavity, and also there are few which are produced by absorption of material from outside the abdominal cavity, such as from the urethra, &c. I have seen infective arthritis in small and large joints, iritis, pleurisy, pericarditis, produced by a gonorrhœal discharge, but so far have not seen septic peritonitis apart from absorption of poison from the peritoneal cavity. The peritonitis associated with gonorrhœa in women,

and the ordinary infective kind connected with the uterus, tubes, &c., I am not alluding to.

As I have doubted the existence of simple peritonitis so do I doubt that of simple meningitis. I am loth to confess that the only three causes known to me clinically of meningitis in children, are tuberculosis, extension of mischief from ear disease, and cranial injuries. One might think that the disease was produced by many causes considering how frequently the word is in use. The long list of distinguishing symptoms and signs between simple and tuberculous meningitis met with in our class-books are of little value.

In later life a few other causes must be thought of, such as syphilis, tumours, &c., but I have never seen meningitis following rheumatism, influenza, pneumonia, erysipelas, &c.; and if these forms do exist I believe them to be most rare.

I have now been through the common clinical causes of pneumonia, peritonitis and meningitis; my object has been in these few short notes to emphasize the importance of always, when using the above words, adding a distinguishing word to them. I am quite aware that under the words of pneumonia, meningitis, orchitis cystitis, &c. &c., the causes or origin of the disease are given in our ordinary text-books, but there is a want of proportion about them, and the common and rare causes are mixed or jumbled up together, and like a tangled net, the threads or causes, as it may be, require much trouble to unwind them. Those of us who have been in practice some few years, or who are fortunate enough to hold hospital appointments, find out sooner or later what value is put upon these causes; but for those starting in practice, or for others who are working in out-of-the-way places and do not possess the medical and surgical advantages as some of us do, would fail to a great extent to estimate truly the value of these causes.

One reason why I think the rare causes of many diseases have a far too great importance attached to them, is that our medical societies, especially perhaps those in London and the great provincial towns, seem to encourage their members to read something that is not commonplace; and so it comes to pass all rare cases and so-called interesting ones are laboriously hunted up and promptly recorded; these are published in the medical journals and obtain a prominence and an

undue amount of weight which is often quite out of proportion to their real clinical value; whereas our common and everyday causes of disease may be neglected, and thus arises a tendency to forget the well-known and useful adage, "Common things most commonly happen," or we rarely meet with rare diseases.

Again, when using such words as pneumonia, peritonitis, a diagnosis of the disease is really not made. A prominent sign is indicated by the words, and, of course, a most important, and possibly a vital one. These terms are placed in all our text books at heads of chapters, and by their prominence seem to call aloud to be treated as distinct diseases. This point is not a fancy one I am asking you to consider, for treatment is the aim and end of all medical knowledge, and the line of treatment which one must carry out depends very much on the qualifying adjective you place before these important words representing these diseases. A few examples illustrating this point will aptly conclude my paper.

A *tuberculous* meningitis, as far as our present knowledge goes, had better be treated on expectant lines; a *septic* meningitis will very probably require active surgical treatment.

The various forms of peritonitis require treatment according to the clinical form we are dealing with. Appendicular peritonitis, if local in position, is cured generally by local surgical treatment, and so each type has its own peculiar treatment.

The ordinary croupous is not the same disease clinically as a septic influenza or alcoholic pneumonia, and the treatment of each, I take it, would be somewhat unlike. In the same way I might discourse on neuritis, cystitis, and so on. My paper advocates thus a clinical rather than a bacteriological classification, and this need not be wondered at, seeing that my work is confined mostly to the bedside and the *post-mortem* room rather than to the laboratory; whereas those engaged in physiological and laboratorical studies would make bacteriology the chief factor in our classification.

The assistance of the clinician and the laboratist is both required, and it is necessary for the full advance of medicine that they work together. Still at present I think the clinician has fallen a little too much in the background and requires a little push forward, to which end these few notes have attempted to contribute.

Report of Proceedings.

Ordinary Meeting—January 8, 1897.

W. BRUCE CLARKE, Esq., F.R.C.S., President, in the Chair.

Mr. STEPHEN PAGET read a paper on "Six Cases of Strangulated Hernia in Infancy or Early Childhood," which is published in full on page 85.

The following discussion then took place:—

Mr. KEETLEY: The escape of intestines through the wound and beneath the dressings in the case of infants who have been operated on for hernia has not been a very uncommon accident. It is one not likely to have been always reported, but I have met with references to the occurrence when reading, and it happened to, I believe, the first infant with hernia I ever operated on. I feel certain this accident can be effectually guarded against by carefully suturing the wound in layers. This is one of the reasons why I myself *am* in favour of taking steps to obtain a radical cure in these cases. I think the shock of the operation will rarely be increased by acting in this way if the following rules be attended to:—(1) Operate from the first with the full intention of doing a radical cure; cut straight down upon the neck of the sac, open it and the peritoneal cavity at the same time; after returning the bowel, separate the sac, high up, from the cord, tie it there, and then sew up the hernial opening so tightly that it will only just permit—if the child be a boy—the cord to pass through. This method includes various principles, some of which we owe to Lucas-Championniere, some to Bassini, and some to others, especially Macewen. It is a method which greatly expedites the operation if the hernia be congenital and the sex male. The child should be kept warm with cotton wool and hot cushions, and the chloroformisation should be reduced to a minimum. In infants it should be merely nominal after the first five minutes.

Mr. MCADAM ECCLES: I would like to endorse Mr. Keetley's remarks that Mr. Paget has read us a very practical paper on an extremely important subject. Mr. Paget stated that all his cases were in male children, but did not give any reason why. The fact can, I think, be accounted for by the consideration that strangulation pro-

bably never occurs unless the viscera have passed into the scrotum, for the inguinal canal can hardly be said to exist in a child less than a year old. Although female infants are not infrequently the subjects of inguinal hernia, it is extremely rare for such to become strangulated. I cannot agree with Mr. Paget in thinking that strangulation is a somewhat rare condition in male infants. Strangulation by no means infrequently occurs—in fact, a congenital hernia seems to be more likely to become strangulated than many other forms—but the necessity of operation for such strangulation, I venture to think, does not commonly arise. As to the causation of strangulation, Mr. Paget says that in three of his cases it came on while the child was at rest; but, surely, unless an infant is sound asleep, one would hardly like to say it is ever at complete rest. I have seen intestine descend merely by the effort of the child raising its head from its mother's arm. I am inclined to think that the distended condition of the bowel with flatus from gastro-enteritis plays an important part in the production of strangulation when the bowel is protruded. As to the fact that the cæcum was found in the sac in three of Mr. Paget's cases, it must be remembered that whereas in the adult it is rare for the cæcum to protrude unless it has a distinct meso-cæcum, and it passes into a complete sac, yet in male infants the subject of right inguinal herniæ the cæcum may be drawn down by means of the gubernaculum behind a patent processus vaginalis. When this occurs it will generally be found adherent behind the sac, not within the sac. With regard to the question of treatment of strangulated congenital herniæ, I would repeat that I believe herniotomy is but seldom required. If a child be inverted, and kept so—not merely for a few minutes, but it may be for half an hour in the majority of cases—the intestine will be spontaneously reduced. I can recall several instances where this procedure has been eminently satisfactory, and the child has been able forthwith to return to its mother and its natural nourishment. Operation, I think, is only to be undertaken in those cases in which evidence of gangrene is present, in which part of the contents remain irreducible, in which a radical cure is determined upon, and the rare cases in which inversion fails to bring about the return of the contents of the sac. I agree with Mr. Keetley as to the not infrequent opening up of the wound after operations on the abdomens of young children, and I cannot help thinking that this is often due, in part at least, to the distension of the intestines with gas, and the consequent tension produced. I would suggest that possibly the introduction of a rectal tube to ensure the free escape of flatus after operation might be of

some benefit. In conclusion, I would add that, having had the opportunity of seeing Mr. Paget's last case during life, and having carefully examined the beautiful specimen he has shown us to-night, I cannot help believing that it was one in which the cæcum had been dragged down by the gubernaculum behind the processus vaginalis, and that in the latter a loop of gut had slipped and become strangulated. Mr. Paget, undoubtedly, reduced this loop, and the child was relieved; but subsequently mischief occurred in the adherent cæcum, which remained in the scrotum possibly as the outcome of the taxis, and that the inflammation set up led to perforation of the cæcum, and extravasation of its contents into the tunica vaginalis lying in front of it.

Dr. McCANN: From my experience of strangulated hernia in infants at the Children's Hospital, Great Ormond Street, I am inclined to think that very few cases ever require operation, as I have seen well-marked examples completely recover after suspension of the child. I am strongly opposed to repeated taxis, whether under anæsthesia or not, as the taxis is an important cause of gangrene of the bowel. The suspension or inversion of the child should be resorted to at once before any attempt at taxis is made. I believe intestinal distension, the result of improper feeding, to be an important cause of hernia and strangulation.

The PRESIDENT: I think that the reason why the difficulty of reduction of these cases of strangulated hernia on the right side in male infants occurs, is a condition which is well shown in one of Mr. Paget's specimens. The testicle is adherent to the cæcum, having acquired this adhesion probably *in utero*. In one or two adults upon whom I have operated, and also in one case of a child, this condition was very obvious, and no sooner was the connection severed than the difficulty in reduction vanished. In two such instances I have found it necessary to remove the testicle, which, I may remark, was atrophied and presumably useless.

Mr. PAGET: I think that it is important to point out that by means of an early operation the danger is avoided of returning gangrenous bowel into the abdomen. Several examples of this disaster have been recorded.

A Plea for the more Precise Classification of Disease.

Dr. W. J. TYSON (Folkestone), read a paper under the above title, which is published in full on page 91.

Skiagram of a Piece of Glass.

Mr. HERBERT MENZIES: This piece of glass, discovered by the Röntgen rays, was removed on December 7, 1896,

twenty-eight days after injuries caused by a medicine bottle breaking in the hand of H. F., aged 12. The wounds had healed when the patient came under my care complaining of pain. The glass was wedged obliquely downwards into the palm, and was firmly gripped by the palmar fascia. The accompanying skiagram, kindly taken by Dr. Barry Blacker, shows the shadow foreshortened.

Ordinary Meeting—February 5, 1897.

W. BRUCE CLARKE, F.R.C.S., President, in the Chair.

The Menopause Viewed from the Gynæcological Standpoint.

A paper was read upon this subject by Dr. ARMAND ROUTH, and is published in full on page 73.

The Psychology of the Menopause.

Mr. C. M. TUKE read some remarks under this heading, the full text of which appears on page 83.

The following discussion then took place upon both these papers.

Dr. HARRY CAMPBELL: The nervousness of the climacteric is not strictly synchronous with the menstrual irregularities of this epoch—that a wave of nervous irritability comes over the woman before the commencement of the irregular menstruation, and lasts for some time after its final disappearance. The same remark applies to the nervousness of puberty, which begins before the flux appears and lasts after its regular establishment. I contend that practically every woman suffers from depression of spirits at the climacteric, and that among the poor, emotional irritability is then often so great as to prompt the woman to lay violent hands on her children. I may refer to the frequency at this epoch of such morbid cephalic sensations as a sense of weight, burning, coldness and irritation, especially in the region of the vertex, and to the common association with vertical headache of a sense of impending insanity—a feeling as if the woman were "going out of her mind." Soreness of the scalp is very common at the climacteric. Mention should also be made of the frequency of post-climacteric monthly manifestations. I have observed this in over a hundred cases, and have traced them to beyond seventy years of age. I am inclined to believe the menstrual rhythm continues in all women to the end of life.

Dr. MANSELL MOULLIN: I have listened with much pleasure to the excellent papers we have had this evening from Dr. Routh and Mr. Tuke, and much regret that we had not the

opportunity of hearing Dr. Hunter's remarks on the medical aspect of the menopause. The subject is one of especial interest to us all, and is not restricted to our patients only, but every female relative and acquaintance has to pass through the ordeal sooner or later, provided she lives long enough. It is a good plan to bring a familiar subject of this kind from time to time before the Society, so that we can pass in review what we know of the matter, and possibly gain something by listening to the experience of others.

Dr. Routh has dealt exhaustively with the local troubles of the vulva commonly met with at this period. There is one, however, to which I may draw attention. The patient usually complains of dyspareunia. Possibly she has recently married, somewhat late in life. The passage seems to have closed up, any attempt at coitus gives her intense pain, and she may go on to say she has a discharge and great pain on micturition. An examination follows as a matter of course; and the cause is at once apparent. The introitus is small, the mucous membrane of the vulva has already acquired that smooth and glazed appearance characteristic of senility, and around the ostium vaginæ are certain red, well defined circumscribed spots extending forwards and involving the meatus of the urethra and extending up the urethral canal. These are exquisitely tender and are bathed in a muco-purulent leucorrhœa. The condition is not that known as urethral caruncle or angioma, but is simply an atrophy of the mucous membrane of the urethra similar to that taking place in the neighbourhood. I believe this condition has been termed "lupus minimus" by a great authority, but the term is a misnomer and only likely to lead to confusion.

Turning now to the more general or medical aspects of the menopause, we find that the period of life at which the activity of the female sexual organs ceases is one of very great trouble and distress. The whole economy of the woman undergoes a complete change, and while this transition is taking place she is subject to many distressing symptoms which have more or less of a pathological character. The nervous system especially appears to be involved. There is no occasion for me to enter into these symptoms, which are familiar to all of us; but they are sometimes very complex, and it is hard to believe that the condition of the patient is not due to something more serious than a functional disorder.

The troubles of the climacteric period are not over in a week or a month; sometimes they extend over a period of years, and few women escape them altogether. The complete prostration of both mind and body, the utter inability to undergo the least physical exertion, the melancholic and

morbid anxiety about themselves which characterise some of these patients, are such as to lead one to fear there must be serious mischief of some kind. In the treatment of such cases drugs are of little value; much more is gained by tact in the management of the case, and above all things it is necessary to reassure the patient and inspire her with confidence. In this a stranger is often able to succeed when the medical practitioner, owing to perhaps more intimate relationship, has not been so successful. The patient has lost her nerve, she is unable to struggle and bear up against her troubles, which are none the less distressing and real because they are not due to organic disease. A line of treatment suggested under such circumstances is sometimes followed by beneficial results which are surprising.

Dr. HENRY SUTHERLAND: I do not believe that the change of life *per se* has much influence in causing insanity at this period. My opinion is based upon an investigation of 100 cases of insanity occurring at the climacteric. It must be remembered that, as Dr. Tilt has observed, "Diseases occurring at the change of life are not the same as those produced by the change of life." Neither do I think the sexual condition of a woman at this age acts as a powerful factor. Single women are as liable to this form of mental disorder as are the married, and the number of children a woman has given birth to does not bear any relation to her liability. Moreover, the attack occurs usually one year after the cessation of the menstrual discharge, and does not appear to be immediately due to that function being obliterated. Moreover, if a case were carefully examined, it would always be found that other causes were at work which combined to produce a break-down in the intellect at this period. Such causes are both moral and physical, such as fright, grief at the death of a relation, cruelty and infidelity on the part of the husband, religious excitement, pecuniary anxiety, fevers, such as scarlatina, typhus and typhoid, overwork, intemperance, inflammation of the uterus, menorrhagia, falls on the head, prostitution or excessive smoking. The form of insanity at the climacteric is usually melancholia, statistics giving not less than 67 per cent. mania 24, dementia 43, epileptic insanity, and general paralysis 2 only. The prognosis is usually favourable, 40 per cent. recovering. The duration of the attack varies between three months and three years, after which period the outlook is hopeless. The average duration of the disease in the 40 cases who recovered was fourteen months and twelve days, or about a year. With regard to the treatment, the best sedative is bromide; mild aperients are also useful. The diet should be light and nutritious, the woman

should lead a quiet, regular life till the catamenia has ceased altogether, suicidal tendencies should be watched for, and she should take plenty of mild exercise in the open air with a cheerful companion.

Dr. McCann: I quite agree with Dr. Harry Campbell as to the continuance of the menstrual phenomena after the blood loss has ceased—for the discharge of blood may be looked upon as an accidental concomitant of menstruation, examples of so-called white menstruation being not uncommon. Cases of early menopause may be confounded with a condition which I believe to be more frequent than is generally accepted, namely, transitory superinvolution of the uterus associated with amenorrhœa, and climacteric signs and symptoms. Some time ago, I saw a patient aged 32 years, who having nursed her first child for eight months had a period of complete amenorrhœa for fourteen months after the cessation of lactation. She complained of marked flushings and other disturbances associated with the menopause. On vaginal examination the uterus was found to be small, the cavity measuring two inches, and there was contraction of the upper portion of the vagina (a well known sign after the menopause). Six months later menstruation returned, with increased size of the uterus, and the patient had continued to menstruate regularly. She did not suffer from anæmia. I have seen in addition two other cases closely resembling the one described.

Dr. Campbell Pope: The first thing which strikes the general practitioner in considering these ailments, especially if their frequency be so great as to imply "a normal course of events," as stated by Dr. Harry Campbell, is the comparative infrequency with which he is consulted upon them. Doubtless the cause is, that the phrase "change of life" has as comforting a significance to the lay mind, in matters medical, as that blessed word "Mesopotamia" had to the aged lady, of whom we have all heard, in matters theological. Otherwise it would be difficult to account for the fact that the same ladies, who in watching so carefully over the period of sexual evolution in their daughters, call in medical aid to their assistance, in their own period of sexual involution allow important symptoms to pass unheeded, attributing them to "the change," and thus instead of being guided by their family physician safely into the haven of a sexual rest, drift into a whole pandemonium of disorders, in many cases to the total ruin of their physical and mental health. The two chief classes of cases on which the general practitioner is consulted are, first, those in which the menopause has occurred too early, and the second, those in which the cessation is unduly protracted.

And this forms one method of classification: in the first group, sometimes, difficult questions arise, such as that of pregnancy in the unmarried, and another important field of inquiry is whether the discharge is ceasing too soon, through the onset of some constitutional disorder, such as phthisis. In the protracted cases it is always well to be specially on guard against structural diseases in the pelvic organs, notably, cancer.

We then come to the various ailments occurring during the process of cessation, and to understand them it is well to consider the physiology of menstruation as regards the blood. The function has two objects, viz., as a purifier, and as a regulator of the volume of the blood. During cessation we are confronted with ailments arising from imperfect depuration, and often from those which arise from overplus in the amount of blood. In the consideration of these two causes we are led to classify the ailments into "toxæmias" arising from imperfect depuration, and "hyperæmias" arising from overplus of blood, prejudicially affecting organs previously weakened—in ordinary language the hyperæmia finds out the weak spot. Notable among the "toxæmias" are the cases of melancholy, and other psychological disorders, brought forward so lucidly by Mr. Tuke, often aggravated by a hyperæmic condition in a previously weak brain. Hence the beneficial use of bromides and purgatives and the ill effects of stimulants, opium, &c., which hinder depuration and promote hyperæmia. Digestive weaknesses will often aggravate toxæmic symptoms, and an error in diet in these cases may be the exciting cause of delusions. I consider it most important to purify the blood and combat local hyperæmias.

Mr. McAdam Eccles: I wish to allude to two points which are of interest to the surgeon in connection with the menopause. The first has a distinct bearing on the psychological aspect of this stage of life. I refer to the question of operations at this period. During a state of nervous irritability, injury inflicted on the tissues tends, I believe, to produce more shock than at other ages. Thus a grave accident or a major operation may be followed by symptoms which are much more untoward than if the patient was younger or older. But there is another view of the case which is also important, namely, the fact that women may have distinct ephemeral attacks of mental aberration, and I think more frequently after operations at this period of life than at others. The second subject is the question as to whether, supposing a woman is the subject of carcinoma of the mamma at the climacteric, does the involution of the sexual functions have any effect, and if so, a marked one on the rate of growth, or arrest of

the new growth? We know that recently it has been urged that oöphorectomy in a woman during the period of sexual activity will arrest the extension of the carcinoma, and lately some most successful cases have been recorded. It would be of much interest to note in cases about the menopause which are beyond operative interference, whether the cessation of the function does have an action on the extensive growth.

Dr. FORBES-ROSS: The condition spoken of as insanity of the climacteric seems not so common when looked at from the standpoint of the same condition occurring in men at an age when, had they been women, the insanity would have been likely to be attributed to the menopause. I have sent in the course of a single year eight males to asylums, and I found that in these cases for the most part there was a substantive derangement of one or other abdominal organ. I have observed that women in active sexual life are liable to affections not so much of the cerebro-spinal system as of the sympathetic, *e.g.*, the paresis of the muscular coat of the bowel, the congestion—passive—of all the abdominal organs, accompanied more or less by marked derangement of their special functions. There are also periodic derangements of the kind at the climacteric. Seeing that certain males suffering from delusions often recover when their deranged digestive organs are treated, with consequent improvement in nutrition, the same might be the case in women, that is, the influence of their sexual system affecting other organs which usually cause a good deal of depression, may really, indirectly, by means of these organs and their influence, eventually come to cause true insanity, though not as the direct and immediate outcome of the climacteric itself. I have never seen a case of insanity in women at the menopause. I have seen many cases of so-called lupus minimus in the practice of Dr. H. Briggs, of the Women's Hospital, but the majority were in young women; these were conditions of local neurotic lesions, which were promptly cured by a superficial application of the actual cautery.

Dr. CHARLES W. CHAPMAN: I have had much success in the treatment of tachycardia at the menopause by a prolonged use of belladonna.

Dr. ROUTH: I must disagree with Dr. Harry Campbell. I believe that the neuroses of the menopause are much commoner in the well-to-do, who have more time to consider their own physical ailments than in the poor. I am familiar with the painful granular areas of the vulva. I am in accord with Dr. Campbell Pope, upon the great danger in the popular belief that hæmorrhages and other troubles at the menopause,

are considered to be merely due to more or less normal attributes of the "change of life;" many lives are thus lost. With regard to Mr. McAdam Eccles' remarks, I believe that acute mania is more common after ovariotomy at the menopause than at other ages. Ovarian "internal secretion" is a very interesting subject. The cure of osteomalacia by oöphorectomy was explicable by the chemical change produced in the blood, but the very recent recovery of recurrent mammary carcinoma after oöphorectomy was, so far, inexplicable. I have not seen any cases of temporary super-involution described by Dr. McCann, and I was much interested in his case.

Mr. TUKE: I am glad to find that as far as the psychology of the subject is concerned, I have few objections to meet, though by the kindness of several members some new points have been raised in discussion. Dr. Harry Campbell has added a very scientific explanation of the symptoms of "flushing." Speaking of this as a mental symptom, I have only to say that I have seen instances of an attenuating sensation of heat and cold; yesterday, for example, I heard of a case of a lady who kept her husband up all night that he might, at short intervals, open and close the bedroom window.

Dr. Sutherland seems rather to throw doubt on the question of the climacteric being the responsible cause of the insanity so often seen at this period of life, and mentions other direct and mastering causes, such as drinking and even smoking. The former cause I mentioned, and I agree with him in thinking that if such an exciting cause can be discovered and removed, it is well for the patient and for the prognosis. But, to my mind, there is undoubtedly a predisposition for a "breakdown" in mental health to show itself at an age when the menstruation is becoming irregular, and the climacteric is reached, though other causes may be in operation.

Mr. McAdam Eccles asks for further light on a possible increased susceptibility to shock in cases of major operations undertaken on women at this period. No doubt there is always a danger of mental symptoms developing after operations, particularly in the organs of reproduction. I have seen two cases of removal of the breast for carcinoma at or about the climacteric, which period is no doubt a fruitful one for carcinoma to appear. The operation was followed in one case by a very severe attack of acute mania; but in the other case, which was apparently the more unstable one, there were no mental symptoms, and the health generally was improved.

Dr. Mansell Moullin's remarks seem to me very interesting, and Dr. Campbell Pope has observed and treated cases in general practice, and has, I think, formed some conclusions

with which I would agree. Many valuable suggestions have been made as to diet and treatment, and the use of purgatives, and the possible dangers of toxæmia. That the use of purgatives are essential I fully assent to; aloin and cascara are very useful, and enemata are frequently valuable. There is, I think, very frequently among women a tendency to extremes—either to neglect the use of aperients, or to use them injudiciously. One speaker has to-night mentioned the common and erroneous notion that at the catamenia, aperients ought to be avoided. Such views should of course be corrected by the medical attendant. I must, however, dissent entirely from an opinion given, that it is among the poorer classes of women that complaints of strange symptoms at the climacteric more often appear, and that it is they comparatively who attach most importance to the manifestations. I would say that there are causes at work such as ignorance, and perhaps a common love of discussing maladies in the lower classes; but it is, I think, the rich and comparatively idle women who can afford the time to give undue and frequently harmful attention and prominence to natural physiological sensations.

Dr. Forbes-Ross raises a question of analogous mental disorders in the male, and the subject is very interesting; no doubt there is a parallel still to be observed in the male, with the same depression and alteration of habits, and disturbance of general health. It occurs sometimes on retirement from active work, and may be associated with changes of the physical condition. But it is not at this age those men frequently break down mentally; and the far greater physiological change which takes place in the other sex would account probably for the more marked frequency of mental disorder in the latter at a corresponding time of the decline of life. I have to thank the members present for so kindly giving attention to my remarks, and for the instruction and pleasure I have derived from the discussion.

Diffuse Bronchitis in Children.—Dr. Renault believes that a simple and harmless method consists in giving a bath at 100·4° F. for seven to eight minutes every three or four hours, until the temperature taken three hours after the last bath has reached 102·2° F. After a third or fourth bath the fever falls and does not rise again, and the disease becomes a slight bronchitis, without even becoming capillary. Quinine sulphate is given as a general tonic.—*Journal des Praticiens*, 1896, p. 205.

CLINICAL EVENING.

Mr. W. BRUCE CLARKE, F.R.C.S., President, in the Chair.

March 5, 1897.

Congenital Ichthyosis.

Dr. CLIPPINGDALE: This child, aged 10, suffering from congenital ichthyosis, is gradually improving. There is a history of an elder brother having been similarly affected, but under treatment the disease disappeared in him at about the age of 20. The eruption in the patient appears under three aspects: (1) in patches, (2) in rugæ, (3) general roughness of the skin. The parts which are exempt are the front of each elbow, the back of each knee, and the face and neck. The exemption of the extensor surfaces (back of knees and elbows) is probably due to friction, and the same probably explains the exemption of the face, the friction taking place during washing; the scalp is also involved.

Aneurism of the Thoracic Aorta.

Dr. CHARLES W. CHAPMAN: This patient, aged 41, has been a four-wheeled cab-driver and accustomed to lifting heavy luggage on to his cab. Early in 1896 he felt a constricting pain across his chest on lifting a heavy trunk, which recurred whenever he did similar work. In April, on stooping down to unlace his boots he felt he would be suffocated. When he presented himself at the hospital on May 26, 1896, his neck and face were swollen and deeply cyanosed, he complained of interscapular pain on the least exertion, which spread across the chest, also a constant dull pain under the sternum and slightly to the right at the level of the second and third intercostal spaces. The veins over the chest, particularly on the right side, were much distended.

On admission dulness was found to be present over the whole sternum and three-quarters of an inch to the right of that bone. A chart taken at the time showing the dulness on percussion corresponded with the shadow shown by the X rays. There has been no dysphagia or tracheal tugging, and the left radial pulse is markedly smaller than the right.

Patient was treated with iodide of sodium and rest in bed for twelve weeks and he is now taking gentle exercise; the symptoms remain practically unchanged.

Sarcoma of Upper Jaw.

Dr. H. P. POTTER: The patient, aged 56, has had this tumour for about nine months; it involves the whole of the upper jaw, is hard and somewhat elastic, the skin is congested and movable, the measurements of the tumour are 5 inches from side to side, $4\frac{3}{4}$ inches from above downwards. It projects from the face $1\frac{5}{8}$ inches, and pushes downwards the hard palate. The nares on the affected side are free. The vision is good. The submaxillary glands are to some extent infiltrated.

Sarcoma of Superior Maxilla.

Mr. MCADAM ECCLES: This patient, who is 52, a few weeks before Christmas, 1896, first noticed pain about the left cheek. Had a number of teeth extracted in consequence. Swelling seen soon after Christmas. Was advised to have operation, but refused. Was seen by me January 30, 1897. Admitted February 4; very marked swelling of left cheek, eye much pushed up; hard palate depressed and nose thrown over to opposite side, and left nostril blocked. Skin very much thinned over the growth, and at the upper part showed a tendency to give way, and the growth to fungate. There was distinct facial paralysis (? pressure paralysis). Glands involved at left angle of jaw.

February 13. *Operation.*—The whole of the superior maxilla removed by Fergusson's method. The skin at the upper and inner part was so thin that it was with difficulty sutured, and has unfortunately given way, and will require a plastic operation. Otherwise patient has made a good recovery. The glands at the angle of the jaw were removed at the same time as the maxilla. When these glands have to be removed it is often advised to put a temporary ligature around the external carotid so as to control hæmorrhage. This was not done in this case, and during the operation the bleeding was comparatively slight.

Renal Calculus.

Mr. F. SWINFORD EDWARDS: The symptoms of stone in this patient, whose age is 32, were present in the left kidney for four years, viz., attacks of hæmaturia and pain in left loin shooting into left testicle and groin. The urine is normal. No hæmaturia since first attack nearly four years ago. I performed nephrolithotomy a month ago. The lumbar

wound had completely healed in a fortnight. Patient left St. Peter's Hospital three weeks after the operation, cured. The stone, which I pass round, is an oxalate one; I think that the symptoms complained of were indicative of a fixed stone in the pelvis, rather than a cortical one, or one loose in the pelvis, and my opinion was confirmed at the operation.

Epithelioma of Abdominal Wall.

Mr. L. A. BIDWELL: This man, who is 46 years of age, was admitted into the hospital on February 3, 1897. He had a large growth on the skin of the abdomen situated between the umbilicus and the right anterior superior spine. It measured 4 inches by 3, and the edges were much everted and fungating. The ulcer was very fœtid. There were some enlarged inguinal glands, and a small growth was also found over the right shoulder. The patient had first noticed a pimple on the abdomen twelve months ago, and this had gradually got larger. Before operation the growth was quite fixed to the deeper parts and could not be moved from side to side, or from above downwards.

The growth was excised freely by an elliptical incision, about half an inch of healthy skin being removed all round the growth. The growth was adherent to the aponeurosis of the external oblique, so this was removed together with it.

A very large raw surface was left after removal of the growth, but the edges were easily brought together after a transverse incision had been made on the outer side, and the two flaps so formed directed up.

The wound was not dressed for a week and then was found to be completely healed, so the sutures were all removed. On dressing the case again, four days later, it was found that the lower angle and middle of the incision had gaped slightly. The wound is now almost healed again. The case shows the advantage of a long transverse incision in cases where large pieces of skin have been removed.

Papillomatous Dermatitis of Anus.

Mr. F. SWINFORD EDWARDS: The disease in this man, whose age is 50, has been four months in duration. It entirely surrounds the anus in a ring $1\frac{1}{2}$ inches broad. It has a definite and raised margin and is covered with papillæ. It reminds one forcibly of condylomata, but the patient's fauces are not affected, nor has he any sign of syphilis. I should like to hear some remarks from the members upon the

question of diagnosis. For my part I believe it to be a case of eczema marginatum, possibly in a tuberculous subject.

Hydrocephalus at Puberty.

Dr. SEYMOUR TAYLOR: This child, aged 14, was born of healthy parents. The head began to enlarge at 7 months of age, and continued to enlarge till about the tenth year. The enlargement is not symmetrical, the left side being most enlarged. He has now signs of descending lesions affecting the crossed pyramidal tracts on both sides. He is fairly intelligent. He has lateral spinal curvature, probably due to imperfect ossification of vertebra.

Mr. MCADAM ECCLES: I would venture to suggest that the curvature of the spine in this case is due to the constant habit of the mother carrying the boy on the left arm, and also that possibly the symmetry of the head is dependent upon a like cause. It is an undoubted fact that when the bones are soft during growth, and before the fontanelles and sutures are closed, much bending and deformity may occur owing to pressure by continual fixture in one position.

Dr. COLMAN: I would like to know if the measurements of the head are increasing at all. I have recently had a case under observation of a boy, 12 years of age, who had been under the care of Dr. Abercombie when a year old, for hydrocephalus. The measurements of his head are now exactly the same as they were in infancy, and are about those of an ordinary boy of his years, and his appearance now does not suggest hydrocephalus. He shows some mental peculiarities, being irritable, very difficult to teach, and generally rather dull. He has, however, an unusual idea of locality, and can make his way almost in a straight line from one part of London to another.

Dr. SEYMOUR TAYLOR: No treatment has been adopted beyond inunction of the scalp with mercurial applications.

Congenital Spastic Paraplegia.

Dr. SEYMOUR TAYLOR: This patient is 8 years of age. His parents are healthy; there is no history of instrumental birth. He has rigidities of all the extremities, especially of the lower, with flexion adduction and increase of deep reflexes.

Dr. COLMAN: Although in the majority of cases of congenital spastic paraplegia there is a history of a lingering labour, often assisted by forceps, the disease occurs in a number of cases of precipitate labour, apparently from injuries

to the head by its being so forcibly forced down the maternal passages.

Dr. SHUTTLEWORTH: I rise to confirm Dr. Colman's remarks as to such cases of spastic hemiplegia being more often due to prolonged pressure in parturition rather than to instrumental delivery. From a considerable experience amongst imbecile children, the subjects of "birth palsy," I may say that the histories showed a preponderance of cases due to protracted pressure without instrumental interference, forceps delivery being noted in only about 3 per cent. of cases, while the former cause figured in over 14 per cent. The practical obstetric inference is not unduly to defer the application of forceps in protracted labours.

Dr. SEYMOUR TAYLOR: I quite agree with Dr. Colman that all such cases were not due to forceps delivery, but many were, and I also agree with Dr. Shuttleworth that it were better to deliver with forceps during a tedious labour, since the pressure on the fœtus's skull during such prolonged labour would be quite as calculated to produce a similar lesion to the Rolandic area.

Congenital Dislocation of the Hip after Operation.

Mr. KEETLEY: This is the girl of 13 who was shown at the December meeting of the Society shortly before operation. (Further particulars of the case are given at pp. 43-4 of the January number of the JOURNAL.) Through an anterior ⊣ shaped incision, the short transverse part of which divides the tensor fasciæ femoris and its sheath, a new acetabulum was excavated in the normal site. The capsule of the joint was then freely opened by a ⊥ cut, the head of the femur turned out of the capsule and worked into the new acetabulum. It is important to note that the bone cut out was exposed by reflecting the fascia and periosteum outwards and upwards in the form of a large flap, which was afterwards used to give a smooth lining to the new acetabulum, and to thus protect *the cartilage of the femoral head from the hard, rough surface of the cut bone.* The considerable range of movement, increasing with exercise, and the freedom from pain and tenderness are, I believe, partly due to this precaution. The joint is absolutely firm, the shortening reduced from 3½ to 1¼ inches, and all who knew the patient before operation consider the improvement very satisfactory.

Tumour in the Male Breast.

This patient, aged about 34, first noticed the growth about twelve years ago. It long remained no larger than a bean or

small nut, but in the last year grew much faster, till it reached the size of a large hen's egg. The inner part is hard and fibrous, the outer soft. On section the latter presented a

To illustrate Dr. Clippingdale and Mr. Keetley's case of malignant tumour of the male breast.

dark red granular appearance. The microscopic report describes it as an adenoma with suspicious signs of epithelial infiltration in some parts.

Psychoses following Operations. — Jacobs (*La Policlinique*, 1896, No. 4) believes that mental derangements which appear immediately after operation permit a more favourable prognosis than those which develop after a considerable lapse of time. He cites several illustrative cases, viz.:— *Case* 1. Acute mania appearing three days after curettage and perineorrhaphy. It disappeared slowly but completely. *Case* 2.—Melancholia in a woman, aged 34, developing six months afier vaginal hysterectomy; death occurred four months later. *Case* 3.—Erotic mania of a violent type; it appeared the day following vaginal hysterectomy, persisted eight days, and then entirely disappeared. *Case* 4.—Mania began on the second day after vaginal castration, and terminated fatally. *Case* 5.—Melancholia developed three weeks after curettage, with insomnia, aphasia, paresis, and death.

The Mirror of Practice.

TWO CASES OF EARLY CANCER OF THE CERVIX UTERI TREATED BY VAGINAL HYSTERECTOMY.

By Frederick J. McCann, M.B., C.M.Edin., M.R.C.P.Lond.

Physician to Out-patients at the Samaritan Free Hospital.

The following cases I have thought will prove of interest to readers of the Journal :—

Case 1.—Mrs. J. (married), aged 54 years.

Previous History.—At the end of February, 1896, she noticed a discharge of blood from the vagina. This continued daily until her admission into the hospital. The discharge was *never offensive.* She did not complain of any pain, and was always able to do her work. For two months previous to her attendance at the hospital the quantity of the discharge had increased. She stated that she was losing flesh.

The menopause occurred seven years previously, and she never had any vaginal discharge until the present trouble commenced. She had had five children (twins twice) and two miscarriages. The last child was still-born.

State on Examination.—She was fairly well nourished, no cachexia. Her appetite was good, and she slept well. On bi-manual examination the uterus was found to be freely movable. There was no infiltration of the broad ligaments. A nodular growth was felt, involving chiefly the posterior lip of the cervix, and extending upwards into the cervical canal.

Per speculum the appearance of this growth suggested malignant disease, the surface bleeding readily when touched.

On July 17, 1896, I performed vaginal hysterectomy. The method adopted was by ligaturing the broad ligaments with silk from below upwards, and separating the uterus with scissors after the application of each ligature. The operation occupied thirty-five minutes. The convalescence was uninterruptedly good, the patient getting up on the fifteenth day and leaving the hospital three weeks after the operation.

The uterus removed has been preserved. Sections made from the growth show that it is a columnar-celled epithelioma. I have seen this patient three times since the operation, the last occasion being in the beginning of February of the present year. On examination the wound was soundly healed, there was no evidence of recurrence. The patient stated that "she never felt better in her life."

CASE 2.—Mrs. L., married, aged 31 years.

Previous History.—For a period of five months she suffered from loss of blood from the vagina after sexual intercourse. During this period also a profuse foul-smelling discharge had been flowing from the vagina. Her menstrual periods were regular, lasting three to four days, until five months ago. She had had two children, no miscarriages. The last child was born six and a half years ago. (Her husband had a chronic gleet.)

State on Examination.—She was a stout woman, of small stature, and somewhat anæmic in appearance. She complained of sacrache and loss of appetite. She was gradually losing flesh. On bi-manual examination the uterus was directed backwards, freely movable, the broad ligaments being free from disease. On the posterior lip of the cervix an ulcerated surface was felt which extended into the cervical canal. The edges of the ulcerated area were hard and composed of a series of nodules. The floor of the ulcer was also formed of a series of small nodules.

Per speculum these nodules could be seen and the surface of the ulcer was bathed with purulent secretion.

On December 17, 1896, I performed vaginal hysterectomy, adopting the method already described. A portion of omentum was found adhering to the fundus of the uterus. This was ligatured and dropped back. In addition the vaginal walls were united with silkworm gut sutures, an orifice being left in the centre through which a strip of iodoform gauze was inserted for drainage. The operation occupied fifty minutes; the convalescence was uninterruptedly good, the patient getting up on January 3, 1897, and left the hospital on January 8. I have seen this patient twice since the operation. She looks and states that she feels much better. Her appetite has improved and she sleeps well. The wound is healed. There is no recurrence. The uterus removed has also been preserved. Sections made from the diseased area show it to be a columnar-celled epithelioma.

The interest of the foregoing cases lies in the fact that they were discovered at an early stage. For this reason they may be looked upon as test cases as regards the operation of vaginal hysterectomy. Should the disease recur in either case, I must confess that my belief in this operation as a radical cure will be severely shaken.

The great importance of hæmorrhage as an early sign of malignant disease is well exemplified. Whenever a discharge of blood occurs from the vagina after the menopause a careful examination of the genital organs should be made. Still the difficulty which is felt by practitioners and specialists is that

such patients do not seek advice until the disease is too far advanced for any radical treatment. This chiefly occurs where no pain exists, and in such cases the onset of pain for which the patient desires relief often indicates the involvement of the pelvic peritoneum and cellular tissue by the disease.

CASE OF RHEUMATOID ARTHRITIS.

By J. Kingston Barton, M.R.C.P.Lond.

The onset in this case was fairly rapid, ending in comparative cure. Apparently the illness was caused by over-feeding, with want of exercise; it was cured by low diet, followed by water and bath cures (Buxton, followed by Harrogate).

Mrs. B., aged 33, seen in March, 1896, was in a typical condition of rheumatoid arthritis—affecting the hands, wrists, neck and ankles; there was slight febrile condition, but not persistent. Patient had been married four and a-half years but had never been pregnant. She had returned from India in May, 1895, having been two years in a part known to give rise to rheumatism; but she had not specially shown any signs of rheumatism while in India. In June, just after her return, she consulted an obstetric physician, who advised her to lie down a great deal and to drink milk freely in addition to her usual foods.

Very insidiously the fingers became affected, and the disease creeping on to neck and shoulders, and feet, in January, 1896, she determined to try the effect of Bath waters and treatment. Her adviser there diagnosed it as rheumatoid arthritis, and, as is often done, advised feeding up, adding good wine to her dietary. She steadily got worse and in March came up to London for further advice. She was then put to bed and treated as a case of subacute rheumatism; salicylate of soda for a time being given, then quinine in saline effervescence, and finally, potass. iodidi in saline solutions with bitters. All milk was carefully removed from the diet, while very light broths, tea, eggs when there was no fever, and such like diet was allowed. On May 1, although much better, yet progress being so slow, Sir William Broadbent saw the patient and said there could be no doubt that the case was one of rheumatoid arthritis and the prognosis could only be expected to be very slow and tedious.

On May 18 Mr. Victor Horsley saw the patient, and he too agreed that it was a typical case of general rheumatoid arthritis. He advised to help the digestive processes by aid

of pancreatine and malt extract. June 8 the patient was sufficiently improved to start for Buxton. She had six weeks treatment there with advantage, and then she went on to Harrogate, where further progress was made; and by October she was able go to Ireland, where she has continued to steadily improve in every way, and as late as January, 1897, I heard of steady improvement, the patient being able to walk and drive and be very busy.

On inquiry it transpired that this patient from childhood knew that milk puddings and milk always disagreed with her, and also she had found by experience that a moderate meat diet coupled with plenty of open-air exercise alone kept her in a healthy condition. Her paternal grandmother, although she lived to old age, was a great sufferer for many years from, and much crippled by, general rheumatoid arthritis. Other members of the family exhibit the gouty and rheumatic diathesis. The very quiet, enervating life in India predisposed the patient to some low forms of her hereditary disposition; and the milk diet with diminished active life in six months nearly placed the patient in the position of a cripple for life. A sister who had spent the latter part of the time with this patient in India, arrived home already suffering from subacute rheumatism in the knees, ankles and neck. In this case it seems to have been induced by much too free allowance of jam in place of butter during her stay in India. It took four months to make her quite well. Salicylate of soda, saline bitters, and very simple diet with rest, followed by a course of Harrogate achieved the cure, and this patient has remained quite well. Four years previously this patient had a sharp attack of rheumatic sclerotitis, which revealed her rheumatic taint.

The lessons to be learnt from this case are, that the older doctrine is correct that general rheumatoid arthritis is a mixture of gout and rheumatism in a subject predisposed to these diseases by heredity. Also that the disease became acute when the digestive functions were much disturbed by a diet that was unsuitable to the patient. Different foods, and debility produced by different causes, may induce the same disease in different persons. Again, each case must be taken on its own merits before deciding on the cause, and before it can be clear what line of treatment will be likely to prove successful.

A CASE OF RECURRENT APPENDICITIS (5 ATTACKS), COMPLETE EXCISION OF APPENDIX IN THE INTERVAL BETWEEN THE ATTACKS—RECOVERY.

By Mr. Charles Andrews, and Mr. C. B. Keetley.

Senior Surgeon West London Hospital.

(*Reported by Dr. P. J. A. Seccombe, House Surgeon.*)

A. H., a married woman, aged 25, was seen by Mr. Charles Andrews, who, diagnosing "recurrent appendicitis," recommended removal of the appendix and sent her into the West London Hospital, under Mr. Keetley, on February 10, 1897. Patient was never very strong, was married four years ago, has had no children and no miscarriages. Catamenia regular. The first attack of appendicitis occurred eight years ago. There was then severe pain and tenderness in the right iliac region. It was accompanied by vomiting, constipation and rise of temperature. She was treated with hot poultices to the painful area, morphia injections and a slop diet; no aperients or enemata were given. She was in bed for about six weeks. Since then she has had four other attacks similar in character though less severe. The last attack was about six weeks ago. On admission to the West London Hospital the patient complained of no pain in the abdomen, the bowels were rather constipated, temperature 99·6°, tongue clean, pulse 88, good volume and strength. The abdomen was normal in appearance and moved freely on respiration. In the right iliac region there was perhaps more resistance on deep palpation than on the left side, but no definite tumour was to be felt. There was very slight tenderness, but no dulness on percussion. Uterus and uterine appendages were normal; heart and lungs healthy.

Operation.—On February 16 the patient was put under ether. Mr. Keetley made an incision about four inches in length in a line drawn from the umbilicus to the centre of Poupart's ligament. The skin and the external oblique muscle were cut through; the fibres of the internal oblique and the transversalis were separated by the closed points of a pair of dissecting forceps, and retracted upwards and downwards.

The peritoneum was now opened. The cæcum was found, but at first it was somewhat difficult to recognise the appendix, which was bound down to the cæcum by adhesions, and formed an elongated nodular mass. The peritoneum and the adhesions formed an uninterrupted sheet over the appendix, so that it appeared as though it were part of the cæcum. The adhesions were separated by the use of two pairs of dissecting forceps and a pair of scissors, and the appendix was cleared

up to its base of attachment. It was then removed at its junction with the cæcum by cutting through it with scissors. Care was taken that none of the intestinal contents escaped from the opening thus made, Dr. Seccombe clamping the gut with his fingers. The hole left in the cæcum was about an inch long, and the edges of mucous membrane were now brought together by a fine silk continuous suture; but owing to the inflammatory infiltration, and adhesion of mucous and other coats of the intestine in the immediate neighbourhood of the disease, this was very difficult to do satisfactorily. The serous and muscular coats were united by Lembert's sutures, silk being also used for these.

Lest the closure of the opening in the cæcum should prove imperfect, the bowel was well brought forward towards the wound in the abdominal wall, and two fine silk sutures were passed through the serous and muscular coat of the cæcum and then through the edges of the peritoneum on either side. The sutures were tied, and thus the sutured portion of the cæcum was brought into immediate contact with the parietal peritoneum, where it lay internally and without tension. The wound in the peritoneum was now completely closed by more silk sutures. The skin and some of the soft tissues were next sutured together with silk-worm gut. The aponeurotic layers of the abdomen were not accurately sutured to one another, as the risk of hernia was thought preferable to the risk of the retention of fæces in the peritoneal cavity. The hole cut in the cæcum, owing to the amount of inflammatory tissue removed, had practically made the operation an enterectomy, and general experience shows that a slight temporary leakage of fæcal fluid occasionally happens after a successful enterectomy, especially about the second week when, presumably, the sutures have partly cut through. The wound was dressed with iodoform gauze and salicylic wool. Small quantities of hot water and beef tea (ʒii. at a time), were given during the night following the operation. Beef tea, and on the fourth day milk, were afterwards given in increasing quantities. The patient was sick four times after the operation. She had very little pain and slept fairly well. Her temperature rose to 100° F. on the night of the operation, but was afterwards never above 99° F., except on March 1 and 2, under circumstances to be described. The bowels were not open until the seventh day after the operation. A small enema of soap and water was then given with very good results though it caused slight abdominal pains. The patient was kept on fluid diet till the ninth day after the operation when solid food was first commenced. On February 28, the twelfth day after the operation, another enema was given. It was followed by a copious motion. She had slight colicky pain in the abdomen during

the day, and in the evening the temperature was 103° F. The wound was dressed, it was healed by first intention, there was slight tenderness over it, but no abdominal distension or general tenderness; the patient had no sickness. Fluid diet was again ordered. The following evening temperature was 101·8°, but no fresh symptoms developed and patient was comfortable. From this date the temperature remained normal, and bowels were open regularly. On March 2, although wound was quite healed, there was still slight tenderness over it. The sutures were removed on March 20.—No tenderness. No pain anywhere in the abdomen. Got up to-day for first time. March 25.—Feels quite well, wound remains perfectly firm. Patient discharged from the hospital. Still wears a pad and bandage over the wound.

Remarks by Mr. Keetley.—This is typical of a class of cases suitable for operation *between* two acute attacks, or rather, after one has subsided. The appendix, with the thickened tissue in which it was embedded—exactly like a fossil in a piece of rock—lay wholly between the mucous and serous layers of the cæcum, and it is not impossible that this arrangement may have been congenital, and not the result of inflammation. Nothing, however, except inflammation, could have produced the mass of cicatricial tissue found, which felt exactly like a tumour of the ileo-cæcal valve, or region, and of a size midway between that of a walnut and that of a Tangerine orange. The incision used is that which I have found most convenient for the operation. The chief points to attend to are (1) the preservation of strict asepsis; (2) very careful suturing of the hole made in the cæcum. Some surgeons do not suture, but merely ligature the base of the appendix. I have twice operated in that simple manner myself, but although the cases did well, I think it was wrong practice. Any ligature would have cut through the appendix in this case, and I have explained that it had apparently no serous sheath of its own. Therefore a complete excision of the appendix, including its junction with the cæcum, was absolutely necessary. The unfortunate subjects of frequently recurring "peri-typhlitis" do not always recover health and strength between attacks, and the effect of such an operation as that here described should be to greatly improve the health and strength of the patient.

Reviews and Notices of Books.

FERNIE ON HERBAL SIMPLES.[1]

TRULY Nature is lavish in her gifts, and particularly so in medicinal herbal simples!

Dr. Fernie in this, the second edition of his work, gives us an elaborate but concise description of nearly four hundred of these plants used in "the humbler art of medicine."

In these days of enlightenment the "herbalist" is rightly suspected by the profession of being a quack; but when science and study are brought to bear, as the author of this treatise has brought them to do so, upon the "herbs gifted with healing," we confessedly read the pages with interest.

Between these covers will be found a vast amount of folk-lore culled from all parts of the kingdom and abroad, much of anecdote and of that which would be of pleasure to the general reader, blended with established medical facts derived from some of our acutest observers.

Some of the remarks are certainly startling; as an instance we note that even in 1879 one had the temerity to say that English doctors in 1876 allowed rheumatism to kill three thousand six hundred and forty human beings, every death being as unnecessary as is a dirty face, because their patients did not have that excellent leaf stalk, celery, prescribed for them!

But such statements as these, irrational as they certainly are, do not militate against the fact that many of our simpler plants are of undoubted, though restricted, use in disease.

Dr. Fernie, in the preface to the first edition, says in the quaint words of Fuller that "My faults I will confess with shame and amende with thankfulnesse to such as will contribute clearer intelligence unto me." We do not profess to be able to do this, but perhaps we may be permitted to point out some omissions and mistakes.

In all times various herbs have been considered of benefit in cancer and other forms of malignant disease.

Within the last few months a belief of such virtue has been revived in connection with celandine. No mention of this is made in the description of the greater celandine; although it is alluded to under the heading of Wartwort.

A somewhat similar omission occurs in speaking of the

[1] "Herbal Simples approved for Modern Uses of Cure," by W. T. Fernie, M.D., second edition. Bristol: J. Wright & Co., 1897.

Comfrey which, according to Professor Thompson, of Ireland, has a power over sarcomatous growths, and this is mentioned when the Vipera Bugloss is being dealt with. We would suggest that these references were placed under their proper headings.

We can find no allusion when watercress and lettuce are being spoken of respecting the possibility that they may be the source of hydatid disease.

On page 315 there is a double error, for the Song of Solomon is not part of the Apocrypha, and the quotation from Chapters ii. and vi. should have the word "valley" in the plural, viz., "I am the lily of the valleys."

A large number of the herbs mentioned appear only, it would seem, to be of use in the hands of the followers of Hahnemann.

PYE ON ELEMENTARY BANDAGING AND SURGICAL DRESSING.[1]

THE seventh edition of this well-known little book has been edited by Mr. Bellingham Smith, who has introduced much which brings it up to date. The chapter on the treatment of wounds has been considerably improved. No mention, however, in this section is made in the details of the preparation of a patient before operation as to *when* the cleansing should be accomplished. No doubt in emergency cases the parts can only be dealt with on the operation table, but where time is available we are convinced that the cleansing, in order to be effective in producing asepsis, should be undertaken if possible two days before the operation, and repeated at least once. Between the two procedures an antiseptic dressing should be immovably adjusted. By this means any secretion coming to the surface from the depths of the skin glands will be sterilised.

We are glad to see such an excellent *résumé* of the dressing of burns. Hot water, we venture to think, but rarely reaches the *rima glottidis* (p. 107) in scalds, and that the dyspnœa present in these cases is really due to the œdematous condition of the parts about the superior opening of the larynx rather than that of the vocal cords themselves.

An erroneous statement made with regard to hæmorrhage from a "burst" varicose vein and found in the former edi-

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[1] "Elementary Bandaging and Surgical Dressing," by Walter Pye, F.R.C.S., seventh edition, revised by G. Bellingham Smith, F.R.C.S. Bristol: J. Wright & Co., 1896.

tions, still remains, we regret to see, in the present one. The loss of blood in these cases, when the limb hangs dependent, is chiefly from the cardiac or upper portion of the vein, and is owing to the incompetency of the valves in the dilated vessels. Thus, the bystander who ties his handkerchief around the limb *above* the site of the wound is undoubtedly doing the right thing, though perhaps unconsciously. Any constriction on the "heart" side should *not* consequently be removed as stated in the work before us. We cannot, moreover, agree that the pupils in concussion of the brain are usually widely dilated. With the exception of these and a few other minor faults, the manual should form a valuable aid to students, nurses, and the more advanced ambulance learners.

SAUNDBY ON RENAL AND URINARY DISEASES.[1]

ALTHOUGH nominally a second edition, this book is now practically a new one. The earlier portion of the first section deals with the pathology of the chief symptoms of Bright's disease, and at the end of each chapter is a summary deduced from the arguments and statements of the various writers quoted. A very exhaustive bibliography is also added after each chapter, and thus any reader wishing fuller information will find no difficulty in collecting the literature. All this early portion is excellent, and Dr. Saundby takes up the position almost of an impartial critic rather than that of an author with very decided views of his own. Passing on to the chapter on History, Classification and Etiology, we find the author still adhering to his former classification of nephritis into infective, lithæmic and obstructive—that is, a classification based on etiology instead of the time-honoured "acute" and "chronic," with its sub-divisions according to the supposed anatomical conditions. We must confess that, while fully admitting the inaccuracy of the older classification, we think that the newer one does more violence to the truth if we are to bring anything like all cases of nephritis within its limits. Thus, although Dr. Saundby in the chapter on etiology refers to exposure to cold as a frequent source of renal disease, we are forced to believe that all such cases occurring acutely in healthy young adults are infective in origin, or we can find no place for them in the classification. In the present state of pathological science we hardly think

[1] "Lectures on Renal and Urinary Diseases," by Robert Saundby, M.D. Edin., second edition. Bristol: John Wright & Co. London: Simpkin, Marshall, Hamilton, Kent & Co., 1896.

this permissible, although in the future we may find that all acute nephritis is infective in nature. Then, again, under chronic lithæmic nephritis we find the case of a man dying at the age of 23 with contracted kidneys, but without any sign of gout, either in himself or his family history. The chapter devoted to treatment is admirably written, and is full of observations on the action of drugs, evidently impartially used and judged by the author himself. In his treatment of diabetes, we are glad to find the author stating definitely, and producing evidence to prove, that a small allowance of potato is desirable, and more than once reminding us to treat the patient and not the disease. There are one or two chemical errors in the book yet remaining, such, for instance, as "chloroform by inhalation gives rise to glycosuria." Physiological chemists are now generally agreed that it is glycuronic acid and not glucose which occurs in these cases. Also $C H_2 \{^{OH}_{OH}$ is called the lowest cyan-alcohol, and here it is not quite certain what the author means, as by removing one of the hydroxyl groups and substituting C N, the remainder of the sentence becomes incorrect.

The book, taken as a whole, is very readable, and is evidently the record of much careful observation and reflection.

SWANZY ON THE EYE.[1]

THE appearance of the sixth edition of this work is a practical proof of the continued popularity which the manual enjoys. It is without doubt one of the best, if not the best, treatise of the kind which is now extant. It admirably meets the want, both of the practitioner and student, being thoroughly practical, scientific, and up to date. The improvements, moreover, introduced into the present edition will add to its value. For example, some pages on "elementary optics" have been omitted, and more space has been devoted to the consideration of the ocular diseases and symptoms liable to accompany gross cerebral disease and diseases of the spinal cord. Again, the subject of tumours of the orbit has been discussed at greater length, as well as their complication with affections of the neighbouring cavities. Mr. Swanzy's book can be highly recommended as fulfilling every requirement for those desirous of having a handy, practical manual upon diseases of the eye.

[1] "A Handbook of the Diseases of the Eye and their Treatment," by Henry R. Swanzy, A.M., M.B., F.R.C.S.I., Examiner in Ophthalmology to the University of Dublin, Surgeon to the National Eye and Ear Infirmary, and Ophthalmic Surgeon to the Adelaide Hospital, Dublin; sixth edition. London: H. K. Lewis, Gower Street, W.C., 1897.

WOAKES ON DEAFNESS.[1]

A BOOK that has passed through the ordeal of four editions can lay strong claims to the title of popularity.

After having carefully read the volume before us, we feel that its title gives but a poor idea of the real worth of its contents, and that its description does not convey to the mind of the observer that the work deals quite fully with the surgery and physiology of the aural, nasal, and pharyngeal regions. So well known a treatise does not require a statement of its contents, therefore it will be sufficient to say that its good reputation has been maintained, and that its matter has been revised, and to a certain extent well modernised.

The tensor tympani muscle does not so certainly receive its nerve supply from the motor division of the fifth, and in the next edition it may be necessary to seek for other paths through which efferent impulses of reflex acts must pass to reach it.

We cannot see that because an otorrhœa disappeared *after* the extraction of a decayed lower molar, its cure was necessarily due to that extraction; on the contrary, we feel that the removal of a decayed tooth which neither ached nor caused local swelling could not exert any curative influence upon a specific inflammation occurring in the auditory apparatus.

And the fact of this same otorrhœa being of a suppurative, and hence of a specific nature, precludes our ability to follow the line of argument that occurs in the following sentence: "At any rate there could be no question in this instance of muscular commotion of the affected organ which might tend to keep up suppuration in it."

This *post hoc ergo propter hoc* method of argument is strikingly exhibited on page 151, where the authors describe how a case of eczema aurium of obstinate duration recovered *pari passu* with the cure of a necrosis of the bone forming the anterior ethmoidal cells.

Our conviction that post-nasal growths are composed of lymphoid glandular tissue is in no manner shaken by the most inconclusive arguments adduced to prove that they are papillomatous. Let it be granted for a moment that their tendency to bleed does render them liable to a comparison to the papillary growths of the mucous membrane of a urinary bladder, even then it is a most misleading simile, for the difference in the microscopical appearances of these

[1] "On Deafness, Giddiness, and Noises in the Head," by Edward Woakes, M.S.Lond., assisted by Claud Woakes, M.R.C.S., L.R.C.P.; fourth edition. London: H. K. Lewis, 136, Gower Street, 1897.

two tumours is so great and marked as to at once negative any further ideas in this direction, and therefore we cannot help feeling that the example advanced by Dr. Woakes to strengthen his case in reality weakens it.

METRORRHAGIA AFTER THE CLIMACTERIC. — Masse (*Revue Internat. de Méd. et de Chir. Prat.*, 1896, No. 6) calls attention to the fact, previously pointed out by Monod, that uterine hæmorrhages may occur after the menopause in perfectly healthy women. These have been noted particularly in stout subjects. Hermann and Tournaux describe certain degenerative changes in the senile uterine tissue which would favour bleeding. The muscular substance is flabby, the vessels of the mucosa are dilated and brittle, and the arteries undergo atheromatous changes. The glands disappear, being replaced by fibrous tissue rich in blood vessels. The treatment consists in applications of liquor ferri or glycerin and carbolic acid, or in curettage. The writer reports the case of a patient aged 76, whose uterus was quite normal. Hot douches and ergotin failed to control the metrorrhagia, which was finally checked by intra-uterine galvanisation.

OBSTETRICAL OCULAR LESIONS. — De Wecker (*Ann. d'Oculist.*, July, 1896) calls attention to the fact that serious ocular lesions, the different varieties of which have not yet been analysed, may occur when the presentation of the child is abnormal, in lengthy labour or contracted pelvis as the result of compression of the cranium, of the orbit, or of the eye itself. In a case that came under his observation the orbit was mistaken for the anal orifice and a most disastrous exploration was made with the finger either inexperienced or anesthetised by compression. As a result of compression with forceps muscular paralyses, especially of the sixth nerve, are quite frequent. As the child grows, concomitant convergent strabismus is developed that has been classed in the category of hypermetropic strabismus. Unilateral congenital ptosis may also arise from the same cause, and in cases of this character it is well to question the mother as to the nature of the confinement. Direct traumatism is rare. In a case cited the cornea was entirely opaque and the mark of the blade of the forceps traversing half the brow and extending to the parietal bone was an evident witness of the cause of the accident. Under treatment by six subconjunctival injections of 5 drops of 1·1000 solution of sublimate, covering a period of six months, the cornea became almost entirely clear. The prognosis of such cases is good.

THE LIBRARY OF THE WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

The appeal made in our last number for volumes to complete our series of the Lancet and British Medical Journal has been so handsomely responded to by the Bristol Medical Library and its honorary librarian, Dr. Griffiths, that in the case of the Lancet we now only need 1890, vols. i. and ii.; 1895 and 1896, vols i. and ii. Of the British Medical Journal we require six volumes, viz., those for 1894-5-6. Moreover, every circulating medical library ought to have duplicates of these periodicals. Of Braithwaite's Retrospect we have not got vols. i., ii., iii., iv., vi., vii., viii., xx., xxii.—xxxv., lii. lxxi., lxxii., lxxiv., lxxviii.—cxiv. We should value also gifts of the following, among others :

American Journal of the Medical Sciences.
The London Medical Record.
Hospital Reports, Centralblatts.
Revue de Médecine.
Revue de Chirurgie.
Brain, Mind, Sanitary Record, Public Health, and other special journals.
Sydenham Society's Publications.
Medical Press and Circular.
Edinburgh, Dublin, Glasgow, and other provincial journals.

A Committee of the Council is considering the question of accommodation, both for the library and for the meetings of the Society, and will shortly, it is hoped, have a scheme ready to lay before the members.

The bound volumes now number about 700, having more than doubled in the past two years. As soon as the figure of 1000 is reached, I hope to print a catalogue in the JOURNAL.

Books presented by THE BRISTOL MEDICAL LIBRARY, PER DR. L. M. GRIFFITHS.

Braithwaite's Retrospect (vols. v., ix.—xix., xxi., xxxvi.—li., liii.—lxx., lxxiii., lxxv.—lxxvii.).
Practitioner (vols. x., xviii., xix.).
American Journal of the Medical Sciences (vols, xci.—xciii., xcv., civ.).
London Medical Record (vol. xiv.).
St. Bartholomew's Hospital Reports (vols. iii.—v., viii., ix., xii., xiii.).
St. Thomas's (N.S., vol. viii.).
St. George's (vol. vii.).
London (Registrar's Report), 1877.
Lancet, 1873, ii., to 1887 (29 vols.), 1889, i., ii.

Presented by MR. LEONARD MARK.

Practitioner, 17 numbers (1895-6).

Presented by DR. C. W. CHAPMAN.

Hunter's "Gravid Uterus," a fasciculus of plates.

Presented by MR. PERCY DUNN.

Phonographic Outlines of Medical Terms, issued by the Society of Medical Phonographers. London, 1895.

The Story of the Gloucester Epidemic of Small Pox, by Francis T. Bond, M.D., B.A.Lond. The Jenner Society, Gloucester, 1896.

A Simple Method of Water Analysis, for the Use of Medical Officers of Health, by John C. Thresh, M.D. J. & A. Churchill, 1897.

The Rules and Bye-laws of the Bradford and District Medico-Ethical Society.

Bread, Bakehouses and Bacteria, by Drs. Waldo and Walsh. London: Ballière, Tindall and Cox, 1895.

Presented by THE AUTHOR.

On Immunity from Disease. An Address, by W. B. Ransom, M.A., M.D., M.R.C.P. London: John Bale, Sons and Danielsson.

Presented by THE PUBLISHERS.

MESSRS. JOHN WRIGHT & CO., BRISTOL.

Elementary Bandaging and Surgical Dressing, by the late Walter Pye, F.R.C.S., 1896.

Herbal Simples, approved for Modern Uses of Cure, by W. T. Fernie, M.D. Second Edition, 1897.

Renal and Urinary Diseases, by Robert Saundby, M.D., F.R.C.P., 1896.

Presented by MR. H. K. LEWIS.

A Handbook of the Diseases of the Eye and their Treatment, by Henry R. Swanzy, A.M., M.B., F.R.C.S.I. Sixth Edition, 1897.

On Deafness, Giddiness, and Noises in the Head, by Edward Woakes, M.D.Lond., assisted by Claud Woakes, M.R.C.S., L.R.C.P. Fourth Edition, 1897.

Dental Surgery for General Practitioners, by A. W. Barratt, M.B.Lond., M.R.C.S., &c. Third Edition, 1897.

Notes on Medical Nursing, by the late James Anderson, M.D., F.R.C.P. Edited by Ethel F. Lamport. Third Edition, 1897.

Presented by DR. SEYMOUR TAYLOR.

Diseases of the Prostate, by Sir Henry Thompson.
Anatomy of the Intestinal Canal and Peritoneum, by Frederick Treves, F.R.C.S.

THE BOOK CLUB.

This, which is worked in connection with Mr. H. K. Lewis's library, is in a flourishing state. Subscription, 11s. 6d. per annum, *now due*.

THE HONORARY LIBRARIAN.

OVARIAN TISSUE IN THE TREATMENT OF CLIMACTERIC DISTURBANCES.—Mond (*Munchener med. Wochenschrift*, 1896, No. 36) reports a number of cases of reflex nervous disturbances following the natural and artificial menopause, in which ovarian tissue was administered with benefit. Ten tablets (each containing a grain and a half of dried ovarian tissue) were given daily. After the second or third day it was noted that the attacks of flushing, perspiration, and mental depression were less marked. After ten or twelve days, or when about one hundred tablets (corresponding to one hundred and eighty grains of ovarian tissue) had been administered, the nervous disturbances were reduced to the minimum. Patients at the normal climacteric responded most promptly to treatment, their symptoms being decidedly relieved as early as the sixth day. The writer admits that a permanent cure cannot be expected in case the reflex phenomena are dependent upon atrophy or removal of the ovaries, but their severity may be mitigated and the period of disturbance shortened. Large doses should be given for the first two weeks, and then smaller doses continued for a considerable period, to be increased if the climacteric troubles reappear. In conclusion, he emphasises the importance of preserving a portion of ovarian tissue whenever this is possible in operations upon the adnexa, in order to preserve the function of menstruation. This applies, however, to cases in which the uterus is preserved, since Glaevecke observed, in fourteen cases in which the tubes and ovaries were spared when the uterus was removed, the same disturbances as after castration. The ovaries in these cases usually become atrophied in consequence of their diminished vascular supply.—*The American Journal of the Medical Sciences.*

POST-GRADUATE TUITION IN LONDON.

By C. B. KEETLEY.

IT was proposed to give in each number of this JOURNAL a full notice of the arrangements for post-graduate study in London, up to date. Strict impartiality was aimed at, and it was hoped that the secretaries and deans of hospitals and schools would supply us with the necessary information. They have responded with a readiness and a courtesy which we are glad to acknowledge. And this article, which has no counterpart in any other journal, has been well received and well noticed.

The London Post-Graduate Course.—Directed by a committee (President, Mr. Jonathan Hutchinson), it combines the following hospitals, viz., the Skin, Blackfriars; Bethlem; and the London Throat, Great Portland Street; with King's College Bacteriological Laboratory; the Parkes Museum of Hygiene; the Cleveland Street Infirmary, and the Institute of Preventive Medicine. There will be a "vacation course" in April, and the "summer term" in May and June. Courses can be taken out separately, and the fees are £1 1s., £2 2s. and £3 3s. at each institution, according to the number of lectures, &c. This does not include hospital practice, for which are charged fees extra, but moderate. The prospectus for 1897 is ready, and may be obtained of Dr. Little, 32, Harley Street, W.

Steps are being taken to erect a Central Institution or "Polyclinic" for the use of the *London Post-Graduate Course.*

Charing Cross Hospital. — Weekly lectures and clinical demonstrations, arranged in three courses of ten each. Two of these courses are given during the winter session, and one during the summer. Fee £1 1s. each course. Thursdays at 4 p.m. Beds, 180; in-patients, over 2,000. Registered medical practitioners not requiring a certificate of attendance, are admitted without fee to the practice of the hospital on application to the dean.

The next course of Post-Graduate lectures will commence on Thursday, May 6. Hon. Secretary, Dr. Willcocks.

West London Hospital.—Weekly demonstrations arranged in three courses of ten lectures each. Wednesdays at 5 p.m. Fee £1 1s. each course. Fees for hospital practice, £2 2s. per quarter extra, or £5 5s. per year, including all lectures and demonstrations. Medical men are admitted to hospital practice free, unless requiring certificate. A class in bacterio-

logy will be formed during summer. Instruction in anæsthetics by the anæsthetists. Hours of visiting and operation, 2 to 5 daily. Beds 101; in-patients, 1,714. When the new wing, nearly finished, is opened, the hospital will contain 173 beds. Clinical clerkships and dresserships. Special departments for diseases of women, eye, ear, throat and nose, skin and for orthopædics. Hon. Secretary, Mr. Bidwell. Propectus on application. (See advertisement.)

Royal London Ophthalmic Hospital, Moorfields.—May and June course, Monday at 1 p.m., Wednesday at 8 p.m. Fee £2 2s.; fees for hospital practice, perpetual, £5 5s.; six months, £3 3s.; and only members of the Post-Graduate Course may join practice for one month for £1 1s. Clinical assistancies. Clinical work begins at 9 a.m. Operations daily 10 to 1 p.m. Ophthalmoscopic and other classes, three courses yearly at 7.30 p.m.; next begins in May or June. Beds, 100; in-patients, 2,184. Secretary, Mr. Robert J. Newstead.

Hospital for Consumption, Brompton.—Summer course of lectures and demonstrations, April to June, Wednesday at 4 p.m. Clinical assistancies (out-patient), attendance in each twice a week at 12 p.m. Clinical clerks (in-patient), twice a week, 10 a.m. to 12.30 p.m., and attendance afternoon of their physicians, three or six months. Fees, inclusive, £1 1s. one month; £2 2s. three months; £5 5s. perpetual. Beds, 321; in-patients, 1,595. For forms, &c., apply to Secretary, Mr. W. H. Theobald.

St. Peter's Hospital for Urinary Diseases, &c.—Clinical instruction in the wards daily. Out-patients, Monday, Tuesday, Thursday, Friday, 2 p.m.; Saturday, 4 p.m., also Monday and Wednesday, 5 p.m. Consultations and operations, Wednesday and Friday, 2 p.m. Beds, 24. Free. Secretary, Mr. Irwin H. Beattie. (See advertisement).

Hospital for Diseases of Skin, Blackfriars.—In "London Post-Graduate Course." Next term, eight lectures. Tuesdays, 4.30 p.m. Beds, 10; out-patients, about 360 a week.

St. John's Hospital for Diseases of the Skin, Leicester Square, W.C.—A course of lectures followed by clinical demonstrations will be given during the next three months on Thursday evenings at 6 o'clock, commencing February 25, 1897. Fee for the course, £1 1s. Beds, 46. Entries to be made with the Superintendent, or with the Lecturer. Apply for particulars to Mr. J. Dunlop Costine, Superintendent.

Throat Hospital, Golden Square.—Lectures and demonstrations "in the winter season." Fee, £2 2s. the course. Dates in medical journals. Fees for practice (including lectures), £3 3s. per quarter; £5 5s. per half year. Clinical assistancies, senior and junior. Attendance at 2.30 p.m.; Tuesday and Friday also at 6.30 p.m. Beds, 28.

London Throat Hospital, Great Portland Street, W.—Monday, 8 p.m., £1 1s.; hospital practice, one month, £1 1s.; three months, £2 2s.; perpetual, £5 5s.

The Victoria Hospital for Children.—The Medical and Surgical Staff propose to give a course of lectures upon "The Diseases of Children." The lectures will be delivered in the Board Room of the Hospital every Thursday afternoon at four o'clock, and each will be followed by a demonstration of cases. Practitioners and students of medicine are invited to attend. Syllabus to be obtained from Mr. D'Arcy Power, 10A, Chandos Street, Cavendish Square, W.

Bacteriological Laboratory, King's College.—In connection with the "London Post-Graduate Course," a course of lectures and practical work, Friday 3 to 5 p.m. Fee, £3 3s. Other arrangements at this laboratory include "a complete course" daily 10 a.m. to 5 p.m. Fee, £5 5s. Evening classes throughout the year, Monday 7 to 9 p.m. Fee, £3 3s. Private study, one month, £5 5s.; laboratories also open for research. For prospectus and further information apply to Professor Crookshank, Director, or to Mr. Walter Smith, Secretary, King's College, Strand, W.C.

British Institute of Preventive Medicine.—Laboratories open from 10 a.m. to 6 p.m. Instruction in bacteriology, bacteriological chemistry, hygiene, and in practical photomicrography. Fee, full month's course, including re-agents, &c., £5 5s. Evening class (from January 6), each Monday at 7 p.m. Fee, £2 2s. Also, in connection with London post-graduate course, every Thursday at 3.30 during summer, urinary chemistry and bacteriology, £2 2s. Open for original research. Apply to Dr. Macfadyen, 101, Great Russell Street, W.C.

Parkes Museum (of Hygiene), 74A, Margaret Street, W.—A course if sufficient entries received, £1 1s.

Central London Sick Asylum, Cleveland Street, W.—Thursday 5.30, "London Post-Graduate Course" lectures, £1 1s. (L.P.G.C.).

There are a few other special hospitals at which special courses are arranged for graduates. All which have the kind-

ness to supply us with particulars will, in future numbers, receive a fair and careful notice.

Mr. Hutchinson gives clinical demonstrations at his museum, Park Crescent, Wednesday afternoons. Free.

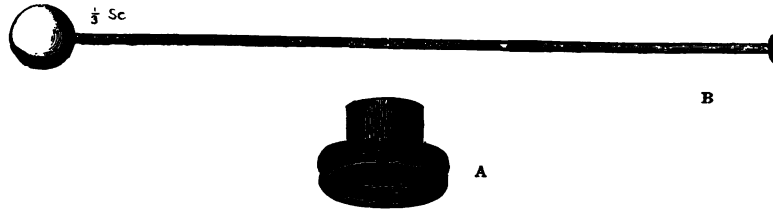
All the great hospitals to which schools are attached are glad to receive visits from graduates, but the latter have necessarily, except at isolated visits, to give way to the regular students and undergraduates. The days and hours of attendance and of the principal operating days are given in the weekly journals.

The museum and library of the Royal College of Surgeons are open daily, and access is readily obtained to them by British, American and foreign graduates and diplomats; Secretary, Mr. Trimmer; Librarian, Mr. Bailey. Special permission is required to visit the museum on Friday and Saturday. Library hours 11 a.m. to 7 p.m. (to 1 p.m. on Saturdays). Museum hours 11 a.m. to 4 p.m. till February 28 (to 5 p.m., March 1 to August 21). The excellent library of the British Medical Association at 429, Strand, is open to members all day. There is a Book Club in connection with the West London Medico-Chirurgical Society.

Disease of Umbilicus in Newborn Children.—Eross, of Buda-Pesth (*Archiv f. Gynäk.*), gives the results of his observations of 1,000 new-born infants. He paid special attention in each case to the mummification and fall of the stump of the cord under different modes of treatment. He finds that ideal cicatrization of the umbilicus with no local or general morbid changes is not the rule after birth. It was observed in 320, or 32 per cent. of the cases. In 680, or 68 per cent., distinct, severe, or even fatal morbid processes had their origin in the umbilicus. These processes were sloughing of the stump of the cord (147 cases); softening instead of perfect mummification of the stump (182); decomposition of fragments of stump overlooked after the rest had fallen (224); suppuration of the navel (109); ulceration of navel (17); and gangrene of navel (2). (The figures, as given by the author, make a total of 681 morbid cases, although "320" is given as the number of cases of "normal cicatrization" in the same table). Out of the 680 abnormal cases, fever was observed in 220. It disappeared before discharge from hospital in 158 of the infants. Fever, Eross concludes, is a very precise evidence —often the sole indication for some time—of infection of the infant's system through disease of the umbilicus. As the infants remained but from eight to ten days in the institution where these researches were made, no precise conclusions as to the course and mortality of the fever could be obtained.

NOTES ON NEW PREPARATIONS AND APPLIANCES.

New Pleximeter.—Dr. Ernest Kingscote has devised a pleximeter which consists of a wooden cone (A), made with a shoulder to which a thick india-rubber ring is attached in such a manner that when the instrument is firmly pressed against the chest the apex of the cone touches a definite point on the skin in the centre of the ring. When the other end of the cone is struck smartly with a hammer having a flexible handle (B) the true note of the underlying structure is elicited. The results have been verified experimentally on recently killed



sheep, pigeon-breasted animals, which are by no means easy subjects for percussion. The dulness shown by the pleximeter is always somewhat external to that elicited by finger percussion. A special form of hammer is used with the pleximeter, its head being made of lamb's-wool so compressed that it cannot be beaten out of shape—a necessary condition for the production of an absolutely true note, and it is of such a weight that the required note is obtained without the absorptive power of the surrounding ring being overcome. The finger may, however, be employed as a hammer with equally good results when the wrist is very flexible. In using the pleximeter it must be applied firmly to the region to be percussed, and there must be no alteration in its position when it is struck with the hammer. The manufacturers are Messrs. Down Brothers, St. Thomas's Street, Borough.

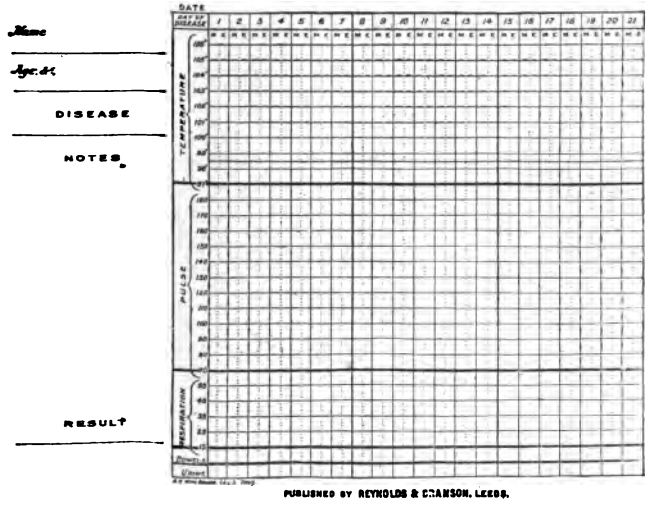
Quinine Salicylate "Tabloids" (3 grs.). Burroughs, Wellcome & Co.—These tabloids have recently been added to the tabloid list. They have been much prescribed for influenza, and are in regular use in the treatment of rheumatic gout. Owing to the fact that quinine salicylate is almost insoluble in water, the tabloid forms a convenient means of administering it.

The same firm have sent us some **Compound Bromide Tabloids** which are useful in cases of epilepsy, &c., where the bromides have to be administered in large doses for a length of time, since the salts of sodium, strontium, and ammonium are less depressing than those of potassium, and a combination of these three bromides with a small quantity of the sodium arseniate to prevent acne, forms a good method of continuous bromide treatment. In the compound bromide tabloids, the dose of sodium arseniate is such as to allow of six tabloids to be given in one dose when necessary. These new tabloids are prepared according to the following formula: sodii bromidi, 2 grains; strontii bromidi, 2 grains; ammonii bromidi, 1 grain; sodii arseniatis, $\frac{1}{60}$ of a grain.

Messrs. Burroughs & Wellcome have also sent us some **Compound Phenacetin "Tabloids,"** in which one grain of caffeine is combined with four grains of phenacetin.

The combination of phenacetin with so useful a cardiac stimulant as caffeine will prove therapeutically useful in many ways. They have an excellent effect in relieving the sick headache of migraine.

Messrs. Reynolds & Branson have made the accompanying chart at the suggestion of Professor Mayo Robson, F.R.C.S.



In the ordinary chart the whole attention is directed to the temperature with very little reference to pulse or respiration.

In many cases the pulse has far greater significance than the temperature, this applying especially to abdominal cases; and it is with a view to being able to compare the daily variations in temperature, pulse, and respiration that the combined chart has been suggested.

The same firm have introduced the silent coal box. Any one who has ever been ill knows how irritating it is to hear the grating of coals as they are chased and coaxed out of an ordinary coal box.

The "silent coal box" is made of almost indestructible material, and will not wear out like the tin sheath of the ordinary sounding coal box.

A few of these "silent coal boxes" are lent on hire at a small charge per week or month.

The "Davidson's" Double Optometer.—This new appliance, designed and patented by Mr. Davidson, of Great Portland Street, W., has much to commend it. It has been introduced for the purpose of facilitating the working out of errors of refraction. From a trial which we have made of the apparatus we can readily endorse all that the inventor claims for it. It is a handy, convenient, useful instrument, and at a cost of four guineas and a half is by no means expensive. Apart from its use for testing the vision, the practitioner will find that it can be employed for ascertaining any defect which may be present in the power of convergence, as well as in the colour sense. The complete sight test dial accompanying the instrument is certainly the most perfect which we have seen.

Action of the Stomach during Sleep. — Examinations of the contents of the stomach obtained in sleep have convinced Schule (*Berlin. Klin. Woch.*) that the acidity of the stomach is greater during sleep, and that its motility is lessened at that period. Persons with digestive trouble therefore, especially if hyperacidity is present, ought not to sleep after eating. Instead, the meal should be followed by wakeful repose.

Notes and News.

In our list of honorary members the past quarter has wrought two changes which must not be allowed to pass without notice. In the first place allusion may be made to the death of Sir Spencer Wells. The full biographical notices which have appeared in the medical journals of this distinguished surgeon render it unnecessary here to pass in review the main features of his active and valuable life. Suffice it, however, to say that the position to which he attained in his profession was honourably won by that determination to succeed which he allowed nothing to thwart. Wells succeeded where others would have failed; the opposition which he encountered at one period of his life would have sapped the courage and destroyed the enthusiasm of many another man, less vigorous-minded, less determined. But despite everything Wells valiantly held his own. He possessed good fighting qualities, but he was not aggressive. At length the practicability of his convictions became recognised and his results the theme of congratulation from those who were formerly opposed to him. Then came his reward. For many years of his life he was carried forward on the crest of a wave of prosperity which has been the lot but of a few to experience.

But another matter concerns us perhaps more closely than that of the death of Sir Spencer Wells in regard to our list of honorary members. We allude to the honour which has been conferred upon Lord Lister. The pæan which resounded throughout the profession when the announcement to this effect was made has even yet scarcely passed away. Lord Lister has been befittingly honoured by his generation, having regard to the great benefits which he has conferred upon it. After all this is something to be able to say. Many another benefactor of his race has not been so fortunate. To Lord Lister, in the name of the Society, we tender our sincere congratulations upon the honour to which he has attained.

The discussion upon the "menopause," which took place at the February meeting, was a decided success, not only from the point of view of the largeness of the attendance, but also on account of the papers and the interest which the discussion excited. Upwards of seventy members were pre-

sent at the meeting, and, as will be seen from the report of the proceedings published upon another page, a large number of these spoke upon the subject. The subject showed that it possessed quite, so to speak, a cosmopolitan interest for the members, if we may judge from the various departments of medical practice to which the speakers belonged. For example, the physician had something to say from his aspect of the case; so had the neurologist and the alienist; and then the surgeon, the general practitioner, and the gynæcologist followed suit. Clearly a subject which was able to attract such a complexity of representatives of medical practice as this established at once its value as a theme for bringing the members of the Society together.

THE Cavendish Lodge (No. 2,620) continues to make excellent progress. It has now found a home, namely, at the Royal Palace Hotel, Kensington. The general feeling seems to be that the members of the Lodge could not have decided upon a more convenient meeting place. At the February meeting a large amount of work was successfully accomplished. Brother Lloyd was raised to the Third Degree, and Bros. McCann and Corbould were passed to the Second Degree; while Messrs. Vivian and Palmer were admitted into Freemasonry. Brother William Travers was unanimously elected a joining member. The brethren and their guests afterwards banquetted together, the number present being about forty. The Worshipful Master, Brother Frederick Lawrance, was in the chair, and was supported by the Immediate Past Master, Brother W. J. Walsham, Brother P. S. Abraham, S.W., and Brother Symons Eccles, J.W.

THE title of the Cavendish Lecture, to be delivered by Sir John Williams on June 25, is "Pregnancy with Ovarian Tumours."

THE staff and their friends have undertaken to organise another dance in aid of the West London Hospital. Upon this occasion the sum collected will be especially devoted towards defraying the cost of furnishing the new wards. The date of the dance has been fixed for Monday, May 31, two days before the Derby, when it is hoped that the preliminary canter in the Queen's Hall on that evening in aid of the charity will be largely patronised, especially by those who have come to London for the purpose of seeing some cantering on Epsom Downs two days later. The first and the most successful dance of the series was that held on Derby Eve in 1890. Upon that occasion the Honorary Secretary had the

mournful duty of returning many cheques and postal orders for tickets which could not be sold, owing to the necessity of limiting the number. The Kensington Town Hall is supposed to afford comfortable dancing space for two hundred and fifty persons; but for the West London Hospital dance of 1890, four hundred and seventy tickets were sold. At least four hundred persons were present at one time, and the dancing, judging from the comments of the dancers, must have been just a little crowded. But excessive good nature prevailed throughout, and even if the dancers were, for a short period, called upon to emulate the lot of tinned sardines, the cause was a good one, namely, that of benefiting one of the most deserving charities in London.

THE profession, save a limited number of practitioners, will rejoice to know that at last public attention has been drawn to the hideous results which have followed the rescinding of the Contagious Diseases Acts in India. The Report of the Departmental Committee appointed to consider the matter caused an immense sensation, and its appearance was the signal for much out-spoken common sense on the part of the lay press, from the *Times* downwards. An almost unanimous conclusion was expressed that the evil should be dealt with without delay by the Government.

WE must not omit to mention that a Festival Dinner in aid of the West London Hospital will be held this year in July. His Grace the Duke of Devonshire, President of the Hospital, has consented to take the chair, and it may be hoped that a large number of the friends of the Institution will foregather upon the occasion and assist in making the reunion a success. The "Festival Dinner" list is lying for signature in the Board Room of the Hospital, and the names of gentlemen willing to act as stewards will be gladly received by the Secretary.

FOR some unexplained reason the name of one of our members, Mr. G. Ley, of 4, Longfield Road, Ealing, W., who joined the Society in 1890, was omitted from the List of Members published in the October issue of the JOURNAL. The Honorary Secretaries have noted the omission, and have made the necessary correction.

WE are requested to state that the Treasurer will be glad to receive the subscriptions of those members who have so far failed to discharge their liability to the Society, and he trusts that this appeal for the unpaid subscriptions will be

quickly responded to, inasmuch as the work of the Society and the publication of the JOURNAL can only be carried on for the small subscription now imposed on members by the prompt payment of the same. And here it may be said that there is no medical society in London, probably not in England, which offers its members so much for the annual subscription. For the sum of only five shillings a year the members have the option of attending (1) a monthly meeting of the Society from October to June; (2) the Cavendish Lecture; (3) a Conversazione; and (4) they receive a copy of the Society's JOURNAL, published quarterly. How is all this done at the price? That is precisely the problem which has puzzled the conductors of so many other similar societies.

THE current year is likely to prove a record one in many ways, apart from the immediate ceremonies in connection with the celebration of the Queen's reign. The "record" which mostly concerns us, however, in the present instance is that of the establishment of the Prince of Wales' Hospital Fund. What will be its outcome? Will it prove serviceable or the reverse to hospitals? Already there seems to be some division of opinion upon this matter. Hospital secretaries are beginning to complain that their annual subscribers are withdrawing their subscriptions and transferring them to the Prince's fund. If this arrangement prevails to any large extent, it is obvious that the charities concerned must suffer. This, however, is more a matter which has to do with the future rather than the present, and it is the latter in which our interest is mostly centred. Take the West London Hospital. If the object of the Prince's Fund is first of all to relieve the hospital charities of their indebtedness, and give them, in this record year, a clean bill of health financially, the West London will greatly benefit in consequence. An outlay of at least £12,000 is required to free the new wing of debt, and it is difficult to see how the authorities of the fund could fail to regard this claim in any other sense than as a paramount one.

P. D.

MICRO-ORGANISMS IN CHOREA.—Meyer (*Jahrbuch fur Kinderheilk*, vol. xi.), after referring to the close clinical relationship which he found to exist between chorea and rheumatism, as shown in 80 per cent. of his own cases, refers to a fatal case of chorea in which a considerable number of pyogenic cocci were found in the blood and in various organs, including the brain. The same micro-organism has been found in the pathological products of acute articular rheumatism. It seems possible that this micro-organism may be the connecting link in the etiology of chorea and rheumatism.

NOTICE.—All communications relating to the Literary part of this Journal, Books for Review and Exchanges should be addressed to the Editor, Mr. PERCY DUNN, 54, Wimpole Street, Cavendish Square, W. Applications for Copies of the JOURNAL, communications respecting Advertisements, and Instruments, Pharmaceutical Preparations, &c., intended for notice, should be forwarded to the Editorial Secretary, Mr. L. A. BIDWELL, 59, Wimpole Street, Cavendish Square, W.

THE

West London Medical Journal.

Published Quarterly under the auspices of the West London Medico-Chirurgical Society.

Original Communications.

THE CAVENDISH LECTURE ON OVARIAN TUMOUR WITH PREGNANCY.[1]

By Sir John Williams, Bart., M.D., F.R.C.P.

Physician-accoucheur to H.R.H. The Duchess of York; Consulting Physician for Diseases of Women, University College Hospital.

The subject which I have chosen for the Cavendish lecture this year is the complication, "Ovarian tumour with pregnancy." Although the condition is not one of great frequency, yet it is not one of very uncommon occurrence, while, by reason of the large mortality resulting from it, the importance which must be attributed to it is great. I have collected 375 cases of the complication, with 461 pregnancies, several of the patients having been pregnant more than once. For about fifty of the cases I am indebted to Mr. Meredith, Dr. Spencer, Mr. Alban Doran and Dr. Herman, who have kindly communicated cases to me which they had met with in practice, and which have not hitherto been published. It is from the notes of these cases that I have put together what

[1] Delivered before the West London Medico-Chirurgical Society on July 2, 1897.

I have to say upon this interesting subject. Unfortunately the notes of the cases are in many instances of a most meagre character; in some they amount simply to a record of the occurrence of the complication, together with the result to the mother and the child, while in others even the fate of the parties most concerned is not stated. Under these circumstances it is difficult, nay, indeed, impossible, to write a full and complete natural history of this serious complication. At the same time a broad outline of it may be obtained from the notes at our disposal.

The first question which demands our consideration is: Is pregnancy a cause of ovarian tumours? Does gestation originate such growths in the ovary? I say that this is the first question, because it has been asserted that pregnancy frequently gives rise to these new growths. To prove this statement—that pregnancy is the cause of ovarian tumour in any given case—is, in the present state of our knowledge of the causes of tumour, not possible, even in the most favourable circumstances, when the state of the ovary has been investigated before the occurrence of conception, and again in the course of pregnancy and labour; nor, indeed, can the negative of the statement be proved, except in cases in which the ovary was known to be the seat of tumour before conception took place, for under these circumstances it is evident that gestation could not have been the cause of the tumour complicating it. If we put the question in another form, however, a form which, although not the exact equivalent of the one I have given, yet so nearly its equivalent that the answer to it must recommend itself to every one as the answer to the question as first put—I believe facts will furnish us with a definite reply. Let me then put the question in the following form: Does ovarian tumour occur with greater frequency in women who are or have been pregnant than it does in women who are not and have never been pregnant? and I think that I shall be able to produce evidence which will enable us to find a definite answer, and that in the negative.

At the very outset of the enquiry, however, we are confronted with this difficulty: that in no large series of cases of ovarian tumour has the effect of the maternity or sterility of its subject been noted. For this reason I have taken the next best material to hand, and that is, a series of cases of ovarian

tumour in which the patients are divided into the married and the single, and I shall regard the married as mothers, and the single as not mothers. This assumption may not be quite accurate, while it is the nearest approach to accuracy that I have been able to obtain. Moreover, the error in it is not so large as would at first sight appear, for the error made by regarding all married women as mothers is balanced by that made by regarding all unmarried women as not mothers.

If, then, we take the 1,000 cases of ovarian tumour operated upon by Sir Spencer Wells and divide them into groups corresponding to the age groups into which the Registrar-General divides the married and the single in the population generally, we obtain the following figures. There were in Sir Spencer Wells 1,000 cases—

	Married.	Single.
Between the ages of 20 and 25 years ...	23 ...	80
„ „ 25 „ 35 „ ...	133 ...	138
„ „ 35 „ 45 „ ...	154 ...	78
„ „ 45 „ 55 „ ...	168 ...	65
„ „ 55 „ 65 „ ...	74 ...	27
„ „ 65 „ upwards ...	7 ...	6

From these it is seen that between the ages of 20 and 25 years ovarian tumour occurs in the single rather more than three times as frequently as it occurs in the married; while between the ages of 25 and 35 it occurs with almost equal frequency in the two classes. After 35 years of age the proportion is reversed, and the disease is met with twice as frequently in the married as it is in the single; between 45 and 55 two and a half times as often; between 55 and 65 nearly three times as often; but in those above 65 years of age it is found in each class with almost equal frequency. Looking at these figures alone, it would appear that pregnancy is a potent factor in the causation of ovarian tumours; for from 35 to 65 years of age, when marriage may be considered to have exercised its full effects, the married contribute a far greater number of ovarian tumours than do the single. Such a conclusion is, however, quite erroneous. This apparent result of marriage arises from the change which takes place in the social condition of the population and the consequent alteration in the number of the married and the single—the number of the married undergoing rapid

increase at the expense of the single. To correct the error conveyed by the figures I have given, we must take into account the proportion of the number of the married to the single in the population generally at the different periods of life under which they have been grouped.

Turning to the Registrar-General's Report for 1891 I find the proportion of the married to the single women to be:

	Married.	Single.
Between the ages of 20 and 25 years ...	30 ...	70
„ „ 25 „ 35 „ ...	67 ...	33
„ „ 35 „ 45 „ ...	83 ...	16
„ „ 45 „ 55 „ ...	87 ...	12
„ „ 55 „ 65 „ ...	89 ...	11
„ „ 65 „ upwards ...	89 ...	11

By comparing these figures with those derived from the 1,000 cases operated upon by Spencer Wells, we shall have a more correct idea of the proportional frequency of ovarian tumours at the several periods of life under which they are grouped.

Now in the series of Spencer Wells we find between the ages of 20 and 25 years 23 married and 80 single women, or a proportion of rather more than 1 married to 4 single, while, according to the Registrar-General, the proportion of married to single women in the total population at this period of life is 30 to 70, or 1 to 2·33; that is, speaking in proportion, 1 married woman produces one ovarian tumour, while 2·33 single women produce four, or 3 married women grow three tumours, while 7 single women grow twelve. Did ovarian tumours occur with equal frequency in the married and in the single between the ages of 20 and 25 years, the number in Sir Spencer Wells' series would not be 23 married and 80 single, but 34 married and 80 single.

In the next group—between the ages of 25 and 35 years—this difference in the comparative freedom from ovarian tumour in favour of married women, becomes still more marked, for in this group in the series of Spencer Wells, I find 133 married and 138 single women. According to the Registrar General's report the total number of married to the total number of single women in the population is as 67 to 33, that is, the married are twice as many as the single; and yet the single women furnish rather more ovarian tumours than

the married. This disproportion is still more emphasised in the two next groups.

Between the ages of 35 and 45 years there were 154 married and 78 single women the subjects of ovarian tumour. Here the number of the married is just twice that of the single. But what is the proportion between the number of the married and of the single in the general population? The Registrar-General states that they are as 87 to 12, or more than seven times as many, and yet, instead of producing seven times as many tumours, the married only furnish us with twice as many as the single.

Between the ages of 45 and 55 years in the series of Spencer Wells, the number of the married is 168 and of the unmarried 65, while in the general population at this period of life the married are to the unmarried as 89 to 11, or eight times as many, and yet they show only two and a-half as many ovarian tumours. The same remarks apply literally to the next group, while the difference in favour of the married is still more marked in women of 65 years and upwards.

Between the ages of 55 and 65 years there were 74 married and 27 single women operated upon by Spencer Wells, while the proportion of the married to the single in the general population is 8 to 1; yet the single present nearly a third as many ovarian tumours as the married, or nearly three times their proper share, were both classes subject equally to ovarian tumours. At 65 years and upwards there were 7 married and 6 single women in Spencer Wells' series, while in the general population there are 8 married for every unmarried woman. At this period of life, then, a number of single women furnish eight ovarian tumours for every single tumour presented by the same number of married women.

I now turn to another aspect of the question. If pregnancy, as has been maintained, is a cause, and a frequent cause, of ovarian tumour, it may fairly be expected that with each successive pregnancy the liability to ovarian tumour would increase. Do we find this borne out in practice? I look for an answer to this question in the cases of ovarian tumour with pregnancy which I have collected, and I find, in the first place, that of the 228 cases in which the number of the pregnancy is noted 87 were primiparæ. This forms more than one-third of the total. Twenty-five of these again were known to be

the subjects of ovarian tumours before conception took place; in 15 the tumour was discovered during pregnancy, and in 57 during labour, or immediately after delivery. The large proportion of the cases in which it was known that the patients were subjects of ovarian tumour before conception, raises the presumption that in some, at least, if not in many of the other cases, had they all been examined, the tumour would have been discovered before pregnancy began. Moreover, if the view that dermoid tumours of the ovary originate during fœtal life or at an early period of life be correct, we shall have to add to the 25 cases in which the tumour was known to be present before conception all the cases of dermoid growth discovered during pregnancy or after. These amount to 57 cases, and thus the number of cases in which the tumour originated before the occurrence of pregnancy is not 25 but 82. This forms more than a third of the total number of cases in which the number of the pregnancy is stated. Again, not only do primiparæ form so large a proportion of the total number of cases, but ovarian tumour with pregnancy does not only not occur with greater frequency, but it becomes on the whole rarer with each successive pregnancy, for among the cases there are—

In the	2nd	pregnancy	...	...	30	instances	only.
,, ,,	3rd	,,	...	...	21	,,	,,
,, ,,	4th	,,	...	...	14	,,	,,
,, ,,	5th	,,	...	...	15	,,	,,
,, ,,	6th	,,	...	...	9	,,	,,
,, ,,	7th	,,	...	...	11	,,	,,
,, ,,	8th	,,	...	...	4	,,	,,
,, ,,	9th	,,	...	...	7	,,	,,
,, ,,	10th	,,	...	...	1	,,	,,
,, ,,	11th	,,	...	...	2	,,	,,
,, ,,	12th, 15th and 19th			each	1	,,	,,
and other multiparæ					26	,,	,,

This shows almost a steady diminution of ovarian tumour with each successive pregnancy, the reverse of what we should expect were gestation a cause of ovarian growth.

These facts, namely—(1) That the proportion of cases of ovarian tumour in the married to the number of married women in the population, is far smaller than the proportion of cases of ovarian tumour in single women to the number of

single women in the population, or in other words, that ovarian tumour is proportionately far less frequent in the married than in the single; (2) That a large number of the cases of ovarian tumour with pregnancy occur in primiparæ, and that 25 of the cases were known to be the subjects of the tumour before conception had occurred, and that 57 were subjects of dermoid cysts, thus making a total of 82 in which the tumours were present before gestation commenced; and (3) That ovarian tumour with pregnancy is met with on the whole with less frequency in each successive pregnancy, appear to show that pregnancy is not a factor in the causation of these growths.

The next question that demands our notice is: Does pregnancy occurring in the subject of an ovarian tumour favour the growth of the tumour? This must be considered under two separate heads—(1) does the process of gestation itself give an impulse to the growth of the tumour, and (2) does the tumour grow more rapidly after labour and during the lying-in period? The first point is, does pregnancy itself cause a more rapid increase in the size of a tumour complicating it? From the commencement of pregnancy until the uterus has been emptied of the ovum, the amount of blood passing through the organ gradually increases and the uterus itself increases in weight, from an ounce and a-half or two ounces, until it attains a weight of eighteen or twenty ounces; while during the lying-in period, the greater supply of blood having been suddenly cut off after delivery, the organ rapidly diminishes in size and weight, until, in the course of about eight weeks, it is reduced to almost its volume before pregnancy. It is well known that fibroid tumours seated in the wall of the uterus generally undergo during pregnancy a rapid growth, similar to that undergone by the uterus itself, and after delivery a like rapid involution. It has been held that ovarian tumours also grow rapidly during gestation because of the increased flow of blood through the pelvic organs, but it has not been held that they undergo involution after delivery, although cases have been recorded in which they have undergone diminution in size. The parallel between the conduct of ovarian tumours and fibroids during pregnancy, to be complete, requires that ovarian tumours should not only increase in size during gestation, but that they should also

undergo a decrease during the lying-in period. The whole argument from the conduct of fibroid tumours as applied to ovarian growths is fallacious, for fibroid tumours are parts of the uterus, composed of tissue like uterine tissue, growing in the substance of the uterus, and undergoing increase and decrease in size from month to month, corresponding to the increase and decrease which takes place in the uterus, while ovarian tumours are apart from the uterus, although their blood supply is intimately connected with that of the womb.

The supposed rapid growth of ovarian tumours during pregnancy has been explained by the great increase in the amount of the blood which flows through the pelvis during the process. This increased flow of blood takes place also when the ovaries and the pelvic organs are healthy, but it is the uterus alone that grows, while none of the other organs in the pelvis, not even the ovaries, present any appreciable enlargement except that due to œdema. It may not unfairly be asked, If this is the case in health, why should it be otherwise in disease of the ovary? But *a priori* and theoretical reasoning justify us in arriving at a presumption only, while it is insufficient to enable us to answer the question under discussion, and we must therefore turn for a reply to the results of observation.

In examining the evidence drawn from clinical observation, which has a bearing upon the question of the growth of ovarian tumours during pregnancy, we should bear in mind certain facts in the history of these tumours, when they exist apart from pregnancy—facts of especial value and importance in this connection, inasmuch as they relate to the rate and manner of the growth of the tumours, when uninfluenced by the process of gestation.

It is well known that some ovarian tumours increase with extreme slowness, while others grow with great rapidity; some grow slowly and steadily throughout the whole period of their existence, others irregularly, by fits and starts as it were, at one time slowly, quickly at another time, and then remaining stationary for shorter or longer periods. We should not forget that the same modes of growth may take place during pregnancy, that the growth may be slow or rapid, regular or irregular. It becomes evident then, that if ovarian tumours in some cases grow rapidly during pregnancy, it is

no proof that the rapid growth is the result of the pregnancy. It is also evident that no general conclusion can be drawn as to the influence of pregnancy upon the growth from the conduct of the tumour in a few selected cases; and I submit, that unless it be shown that ovarian tumours not only grow as a rule during gestation, but that they grow at a more rapid rate than that commonly observed in them apart from pregnancy, we are not entitled to conclude that their growth is favoured by pregnancy.

Now, in the notes of most of the cases which I have collected nothing is said about the growth of the tumour, but certain statements are found in them, from which we may fairly infer that the increase in it, if any, was slow or rapid. Such statements refer to the size and position of the tumour, and the number of pregnancies which it accompanied. I judge that all tumours which, at the time of delivery, were situated entirely in Douglas' pouch or in the pelvis, by reason of their size, and all tumours smaller than the fœtal head, could not have grown rapidly or at a rate unusual apart from pregnancy.

Now, twenty-four of the tumours are described as being small at the time of delivery, while ninety-four were situated in the pelvis, all of which I regard as small tumours, which could only have grown slowly. Again, a tumour which had accompanied two or more pregnancies could only have increased at a slow rate, although it had ultimately attained a large size. Of such cases there are forty-five, some of which had been pregnant twice, some three times, and some five or six times, while subjects of the growth. The total number of these pregnancies is 131. In these the growth of the tumour must have been generally slow, and pregnancy could not have hastened it, and they must, I think, be classed with those cases in which gestation gave no impulse to the growth of the tumour.

Further, we have definite statements made as to the rate of growth of the tumour in a certain number of cases, while in others no such statements are made. I shall, however, consider that such tumours as required tapping more than once in the course of pregnancy increased at a quick rate, and these cases I shall include among cases of rapid growth.

I find that the tumour increased in size in fifty-seven cases.

It is simply said to have grown in twenty-three pregnancies, grown slowly or gradually in eight, and greatly or rapidly in eleven. To the eleven cases in which the growth was rapid I must add fifteen in which the tumour was tapped twice or oftener. This makes twenty-six cases in which the tumours grew rapidly.

Of the cases of rapid growth, the increase occurred in one after the eighth month, in another after an attack of variola; in a third after rupture of the cyst and symptoms of peritonitis, while in a fourth the tumour was growing rapidly before conception took place. Among the eleven cases in which rapid growth took place without tapping there are therefore three in which the growth may be accounted for by other causes than pregnancy, leaving eight in which pregnancy may have given the impulse to the rapid increase. In fifteen cases tapping was resorted to, doubtless with a view to relieve symptoms arising from the great size of the abdomen, but it is not clear whether these arose from the increase in the size of the tumour or from the increase in the size of the uterus. After having been tapped they evidently refilled or grew rapidly for they were tapped again, and sometimes again and again in the course of the pregnancy. It is well known that tumours, apart from pregnancy, which have been tapped, frequently refill again or grow rapidly, and for this reason there is nothing in the histories of these fifteen cases to show that pregnancy accelerated the growth of the tumour.

In the twenty-three which are said to have grown simply, and the eight which are said to have increased slowly, there is nothing to indicate that the growth were other than that commonly seen in tumours apart from pregnancy, or that pregnancy exercised any influence upon these growths, and I think that they should be accordingly classed with the cases which followed their natural course as if they were uncomplicated by pregnancy.

There is another fact which should be borne in mind in this connection, and which is illustrated by several of the cases, and that is, that ovarian tumours present the same irregularities in the rate and mode of their growth during pregnancy, as they present independently of that condition; for in some cases the tumour grew rapidly before pregnancy, and ceased to grow after conception; in some it grew steadily before and

during pregnancy and after delivery; in some it grew only during a part of the period of gestation, and in some after delivery only. There is no uniformity in the conduct of the tumour in different cases. The whole of this evidence and the small number of the cases in which the growth of the tumour was rapid, appear to show that pregnancy exercises no influence in accelerating the growth of ovarian tumours.

The second part of the question relating to the growth of ovarian tumours in connection with pregnancy is, what is the effect of delivery and lying-in upon it? Is it to accelerate it? It has been held that delivery, by diminishing the intra-abdominal pressure, relaxing the tension of the abdominal walls, and removing pressure from the tumour gives rise to rapid increase in it. I will not discuss this theory, but simply state that I attach no weight to it, and proceed to lay before you the facts which I have collected bearing on the question, and which, to my mind, furnish the answer to it.

After 69 deliveries the tumour appears not to have grown, and after 32 it increased in size. In one of the 32 cases a sudden increase took place on the fourth day; in another a like increase occurred on the ninth day; 9 of the cases are said to have increased slightly, slowly or gradually (1 during an attack of peritonitis, and 1 suppurated); 11 increased rapidly, 3 of them with peritonitis, or while undergoing suppuration.

The sudden increase in 2 cases, the one on the fourth and the other on the ninth day, is probably due to twisting of the pedicle, or hæmorrhage into the cyst, while peritonitis or suppuration was probably the cause in three cases. This leaves 8 cases in which there was rapid growth of the tumour after delivery, and 69 in which there was no appreciable growth, and 19 in which there was no unusual growth; that is, a total of 88 cases in which there was no unusual increase, and of 8 in which the tumour grew rapidly. These figures seem to show that the influence of delivery, and the puerperal processes, is not to accelerate the growth of ovarian tumours.

There are some observations in the notes which are interesting in this connection, because they refer to another kind of change in the ovarian tumour after delivery—a diminution in size instead of an increase.

In one case observed by Dr. Milne, the patient had three children, and the tumour is said to have diminished in size

after each pregnancy. In one case, the cyst ruptured during labour, and no trace of it could be found during a subsequent labour. In another the cyst burst some time after the puerperal period, and the abdomen was tapped. No trace of the cyst could be found at the following labour. In another the tumour disappeared, and the patient had two children afterwards. In another the tumour disappeared and could not be found in a subsequent pregnancy. In another the tumour was tapped twice and drained after the second tapping; the cyst suppurated, but gave no further trouble. The patient had living children subsequently. In another the cyst suppurated and discharged pus and hair, and gave no trouble at the next confinement; and in a case recorded by Dr. Robert Lee, the tumour decreased considerably in size after delivery and the administration of liquor potassæ.

Of the eight cases the tumour is said to have decreased in size after delivery in two: to have disappeared with or without rupture in four, and to have given no trouble after having undergone suppuration in two.

The cysts which disappeared not to refill after rupture may have been, and probably were, cysts of the broad ligament.

I pass on now to consider very shortly the question of the relation of pregnancy to malignant disease of the ovary. Leopold has made the extraordinary and startling suggestion, that pregnancy is a cause of cancer of the ovary; and Wernich holds, that pregnancy occasions malignant degeneration of ovarian cysts.

Leopold bases his suggestion upon two cases—one published by Spiegelberg, and one observed by himself.

Spiegelberg's case is briefly as follows:—The patient, who was 36 years old, was pregnant for the second time, was delivered of twins on March 20; one was dead at birth, and the other died in the course of a few hours. The tumour was discovered after the delivery. On March 30 the patient died uræmic, with peritonitis, the result of hæmorrhage into the cyst and rupture of it. Both ovaries were changed into masses of myxo-sarcoma carcinomatosum — no trace of ovarian tissue remaining.

Leopold's case regards a patient 36 years of age, pregnant for the third time. She bore her second child in her 34th year, after which she menstruated regularly until her 35th,

when menstruation ceased and in December, 1863, she gave birth to a six months' fœtus. After her delivery the doctor discovered an abdominal tumour, the nature of which was not clear. Puncture proved it not cystic. She died about two months after her confinement. Each ovary was of the size of a man's head, and a mass of medullary cancer.

These two cases form a very slight foundation for the theory that pregnancy is a cause of cancer of the ovary. Even if it were known that both ovaries had become the seat of disease in the course of pregnancy, Leopold's theory would be almost like a pyramid standing on its apex. But even this meagre knowledge is not forthcoming, for in both cases the tumour was not discovered until after delivery, and the state of the organs at the time of conception is not known, and the inference that the disease began in the course of, and was caused by, pregnancy is a pure assumption. Indeed, the only conclusion which can be drawn from these two cases, is, that the ovaries were not entirely cancerous at the time of conception, that a portion of the ovarian tissue was healthy and capable of discharging an ovum.

Wernich's view that pregnancy gives rise to malignant degeneration in previously benign growths, is based upon an equally slender foundation—namely, two cases—one observed by himself and one by Kursteiner. The original report of Kursteiner's case I have been unable to obtain, and the extracts given from it by Wernich are of too meagre a character to be of any value.

Wernich's case was a woman 20 years of age, who had suffered from pleurisy for a long time, and was known to have a tumour in the abdomen, the nature and point of origin of which were doubtful. Whether there was any relation between the tumour and the pleurisy is not stated. The tumour, however, gave the woman no trouble, and remained indolent for one year. She conceived and miscarried at the eighth month. Shortly before the miscarriage she complained of violent pain in the tumour. She rapidly lost flesh, and died three weeks after her delivery. No marked growth of the tumour was observed during pregnancy or after delivery. Labour was not hindered by it. At the autopsy the right ovary was found to be a mass of medullary cancer, breaking down in places. No trace of the original structure of the

ovary was discovered, but in the tumour was found a small cyst having glairy contents with papillary growths on its inner surface. , The remarks made respecting Leopold's view, and the reasons for them are applicable to Wernich's; but further, in considering Wernich's view, it should be remembered (1) that cancer is occasionally found in cystic tumours of the ovary, and (2) that after the removal of cysts, which appear to be of a benign character, malignant disease sometimes develops in the stump of the pedicle, and in these two well-known facts are to be found, I think, the explanation of Wernich's case, and not in what I must characterise as a far-fetched theory of a malignant influence exercised by pregnancy.

Moreover, cancer of the ovary, apart from pregnancy, is not very uncommon, but I have no means of judging of its frequency except by my own experience, and if I may judge by that, cancer of the ovary with pregnancy does not appear to be proportionally more frequent than cancer of the organs apart from that condition. Indeed, the total number of cases of cancer of the ovary with pregnancy which I have collected amount to only 14 cases. I have attempted to show that pregnancy does not originate ovarian tumours, benign or malignant, that it does not accelerate their growth, and that it does not cause malignant degeneration of benign tumours, and I proceed to describe what I consider to be the effects of gestation, delivery, and the puerperal processes upon these growths.

These effects are various, and depend partly upon the situation of the growth, whether it is in the abdomen or in the pelvis. They are due to the movements of the uterus, its size and the pressure exercised by it upon the tumour, its contractions, the expulsion of the fœtus, and the pressure made by the child as it passes through the pelvic canal. These effects are twisting of the pedicle, rupture and laceration of the tumour and their consequences, hæmorrhage into the cyst and suppuration.

Twisting of the pedicle is an accident of frequent occurrence, and among the cases collected it is said to have occurred in 21 instances, or about 6 per cent. In one case the cyst was twisted off from its original attachment, and had become attached to the omentum, whence it derived its nourishment.

Twisting of the pedicle occurs in women who have not been

pregnant as well as in mothers. Roktansky met with it in 8 instances out of 58 women who died of ovarian disease. This *post-mortem* experience, however, gives us no idea of the frequency with which the accident occurs in cases generally, nor of its relative frequency in those who have and those who have not been pregnant while subject to an ovarian tumour.

Spencer Wells found the condition in 18 or 20 cases among his 1,000 operations, or in 2 per cent.; he does not give the numbers he met with in the married and those in the single. In his series, however, the married exceeded the single by more than a third, and it may therefore be inferred that a majority of cases of twisted pedicle was found among the married. Be this as it may, it is clear that twisted pedicle is found nearly three times as often in cases of ovarian tumour with pregnancy than in ovarian tumour apart from pregnancy. This seems to show that pregnancy is a powerful factor in causing this accident, and consequently one that adds greatly to the danger of the disease.

The situation of the tumour would, on *a priori* grounds, appear to affect the frequency of rotation, and tumours in the abdomen might be expected to be more subject to this accident than those situated in the pelvis by reason of their greater mobility and exposure to the influence of the abdominal organs. Experience confirms the accuracy of this view, for 11 of the cases in which rotation had occurred were cases of abdominal tumours, while 3 only were pelvic, and in 7 the situation of the growth is not stated.

Besides twisting of the pedicle another accident, sometimes due to twisting of the pedicle, but often not, is liable to happen. It occurs sometimes during pregnancy, but much more frequently during labour and after. This is rupture of the ovarian cyst. It happens apart from gestation and parturition, and Spencer Wells met with it twelve times in his last 500 cases, or in 2·4 per cent. In the 375 cases of ovarian tumour with pregnancy I find that it occurred 13 times, or 3·5 per cent., during gestation, that is, with somewhat greater frequency than in cases generally. A fact which I have already mentioned in connection with twisting of the pedicle should be borne in mind in this connection also, that is, that in Spencer Wells' series the married were consider-

ably in excess of the single—for it probably has a distinct influence in approximating the percentages of rupture. It appears, in any case, that although the tendency to rupture of ovarian cysts is small, pregnancy exercises a slight influence towards increasing it.

During labour and after parturition the danger of rupture is far greater than it is during pregnancy, for it happened in 35 or nearly 10 per cent. of the cases and 8 per cent. of the pregnancies. The great frequency of this accident during labour is not to be wondered at, seeing the pressure exercised upon the tumour by the forces of parturition, and especially when the growth is situated in the pelvis. If we add—as we should in estimating the natural frequency of this accident—if we add to the 35 cases mentioned, the cases in which the tumour was situated in the pelvis, and causing an obstruction to the passage of the child, but which escaped rupture by the aid of the doctor, through some being pushed up (19), some tapped (20), and some escaping through a rent in the vagina (3), we obtain a total of 77 cases, in which rupture was inevitable, had not art intervened or the vagina given way. We should expect rupture of the tumour to occur, then, in 20 per cent. of the cases.

The frequency of rupture depends largely upon the situation of the tumour. Of the 13 cases in which rupture took place during pregnancy, 8 were in the abdomen; the seat of the other 5 is not stated. All these burst into the abdominal cavity with two exceptions; one opened into the bladder, and one suppurated and burst at the umbilicus.

Of the 35 cases in which rupture took place during labour, the tumour was in the abdomen in 19 instances; in the abdomen and pelvis in 5, and in the pelvis in 8; while its seat was not noted in 3; so that of the total cases of rupture during pregnancy and labour, in 27 the tumour was in the abdomen, and in 13 in the pelvis partially or entirely. Thus it would appear that the danger of rupture is twice as great when the tumour is in the abdomen as when it is in the pelvis; but inasmuch as reposition or tapping was practised, or escape through a rent in the vagina happened, in 42 cases, in which the tumour was in the pelvis, these should be added to the 13 which burst, and then we have 27 abdominal and 55 pelvic tumours ruptured. All pelvic tumours, unless they

escape into the abdomen, must be crushed during labour, while about 8 per cent. of abdominal tumours burst during pregnancy and labour.

The rupture takes place in various situations: into the cavity of the peritoneum, the vagina, bladder, rectum, or at the umbilicus. In the great majority of cases it takes place into the peritoneum.

Hæmorrhage into the cyst is noted in a few cases.

Suppuration is rare in ovarian tumours during, as it is apart from pregnancy. It occurred in 6 cases; in 2 without apparent cause, and in 4 after tapping—a most frequent cause of suppuration in the absence of pregnancy.

Suppuration occurs more frequently after labour than before delivery. It happened in twelve instances. Two of these had been tapped during pregnancy, but this may not have been the cause of the suppuration, for during labour other fruitful causes of suppuration often come into play, especially inflammation and sepsis. To sepsis may perhaps rightly be ascribed all, or almost all, the suppurations which take place after delivery, and with the means now at our disposal for preventing infection, we may expect far better results, as respects suppuration, than those hitherto obtained.

I have now finished what I have to say respecting the influence of pregnancy upon ovarian tumours, and I have yet to consider the influence of the tumour upon pregnancy, labour and lying-in.

How often pregnancy is interrupted in its course in the population generally by accident, or disease, or without apparent cause, we have no means of deciding; but it is certain that abortion and premature births are of very frequent occurrence. We cannot expect it to be otherwise in the subjects of ovarian tumour, and we find that abortion or premature labour occurred spontaneously in 58 out of 461 pregnancies. How many of these premature terminations of pregnancy were due to the presence of the ovarian tumour, and how many to causes independent of pregnancy, I have no means of deciding. Seven were premature labours, and 26 abortions. No cause for the occurrence of premature emptying of the uterus is given in most of the cases, but

twisting of the pedicle was present in 1, peritonitis in 2, tubercle in 1, renal and hepatic disease in 1.

In 24 of the cases the tumour was cystic and in 5 dermoid, the total of cystic tumours being 221, and of dermoid 71; so that abortion appears to be somewhat more frequent with cystic than with dermoid tumours.

In 16 cases the tumour was in the abdomen, in 8 in the pelvis, partially or wholly. The size of the tumour, if it be large, or if twisting of the pedicle, or rupture, giving rise to peritonitis, have occurred, may excite uterine contractions and abortion; but the notes of the cases throw little or no light on the subject.

Abortion or premature labour occurred in 8 out of 14 cases of cancer, and was induced in 1, while nothing is stated upon the point in 5, so that cancer appears to have a baneful influence on gestation.

Of the solid tumours nothing is said except that premature labour was induced in two pregnancies in the same patient, and abortion occurred in one at the sixth month, ovariotomy having been performed at the fourth.

I come now to consider the part played by ovarian tumours in labour. This depends firstly and largely upon the situation of the tumour, and secondly, and in a less degree, on its size. When the tumour is placed in the pelvis, even when of comparatively small size, it impedes the passage of the child; on the other hand, if it be situated in the abdomen, it depends mainly upon its size whether it does or does not interfere with the progress of labour.

When of large size it enfeebles the expulsive forces and causes respiratory and cardiac suffering; but when small, labour proceeds as if the tumour were not present. Among the cases I have collected there are 178 (or about 2 out of 5), in which the labour was more or less natural, that is, delivery was effected without artificial help. Of these 7 are described as easy, 5 tedious, 13 natural, 1 slow, 2 difficult, and 2 lingering; and in one hæmorrhage occurred at the eighth month. This is not a bad result, but it gives no idea of the difficulties caused by these tumours during delivery. To realise these difficulties we must look to the cases which required artificial help, and to the examination of these I now turn.

The means which have been employed to overcome these difficulties are reposition, or raising the tumour from the pelvic into the abdominal cavity, so as to place it out of the way of the descending head. In many cases this could not be accomplished, then tapping was resorted to, forceps, version, craniotomy, and Cæsarean section, or ovariotomy, as circumstances, may I be permitted to say, dictated.

Of these measures of relief reposition is the simplest and least dangerous. It was carried out in 22 cases. In one of the cases tapping was resorted to before reposition was accomplished; in 3 forceps were employed after reposition; and turning in 4; abortion was induced in 1 (a case of cancer) after reposition. Omitting the case of cancer there are left 8 cases in which reposition was insufficient. The results I will state later. Reposition failing, the next simplest means of relief is the reduction of the size of the tumour by tapping, and this often proves effectual in permitting delivery to take place. Tapping has been resorted to at two different periods—during pregnancy and during labour.

During pregnancy this operation is undertaken with the object of giving relief from distension and the distress it produces, and it was resorted to in 39 cases. Of these 20 were tapped once, in 1 of which the cyst was drained and injected, followed by abortion and the death of the mother; in 10 pregnancy appears to have gone to the full time; in 2, abortion took place, the cyst suppurating in 1; in 2 the cyst opened into the bladder; in 5 ovariotomy was performed soon after the tapping; in 5 the tumour was tapped twice; in others it was tapped from three to eight or several times; in 1 the tumour suppurated, and the uterus was tapped in 2. Of the 21 cases in which the tumour was tapped during labour all being pelvic 11 were delivered without further aid, while the forceps were resorted to in 5, craniotomy in 6, and turning in one; suppuration of the tumour followed in 2.

The forceps was employed in 36 cases: in 23 of them the tumour was situated in the pelvis and in 6 in the abdomen; the position in the other 7 is not stated. The forceps proved successful in effecting delivery in 32 cases and unsuccessful in 4. In 7 cases they were employed after tapping, reposition proving impossible, or when accomplished proving insufficient.

Delivery by forceps was followed by rupture of the vagina in 5 cases and of the tumour in 3 and by suppuration in 1. In the cases in which the tumour was ruptured the contents escaped by the vagina, and in the case in which rupture of the vagina took place the contents of the tumour or the tumour unruptured escaped through the rent and was removed. These results are of a very grave character, for rupture of the vagina occurred in one-seventh and of the cyst in one-twelfth of the cases.

Version was practised in 20 pregnancies. The tumour was pelvic in 16, abdominal in 4. In 3 reposition was attempted, and in 1 the tumour was tapped; in 3 the cyst burst during labour, in 1 into the vagina. Rupture of the uterus occurred in 1; the labour was premature in 1; the breech presented in 1 and the abdomen in 1. Four of the tumours were dermoid and six cystic. One is described as "scirrhus," which probably means fibroid, because hard tumours went under that name, and in this case the mother lived for two years afterwards.

Craniotomy was resorted to in 36 cases; with one exception the tumour was situated in the pelvis entirely or partially. The exception was a case of Merriman's, and the tumour was in the abdomen. Efforts were made to deliver by the vectis, but unsuccessfully, and the perforator was therefore employed after the woman had been in labour for three days. Seven of the tumours were dermoid, 8 cystic; 1 was malignant and 1 solid. Reposition was unsuccessful in 1; tapping was done before destroying the child in 6; the forceps or vectis were employed in 5. Labour was premature in 1.

Premature labour or abortion was induced or followed after operative measures in 30 instances. In 12 of these abortion followed soon after ovariotomy, in 2 others after six or eight weeks, so that its cause was probably something other than the operation. In 5 abortion followed tapping; tumour being drained in 1. In 2 it followed tapping and ovariotomy. The uterus was tapped in 2, and the sound was introduced in 2. Suppuration followed tapping in 2. The method adopted in the other cases is not stated.

Ovariotomy was performed in 70 cases during pregnancy and in 2 during labour. Of 19 of the cases I have not been able to find the details except respecting the mortality. Of

the 51 remaining, 30 were operated upon before the fifth month; in 17 of these the pregnancy went on uninterruptedly; 8 aborted, 2 apparently spontaneously after having recovered from the operation. In 13 the operation was performed after the fifth month; 7 aborted or miscarried, 2 after recovery and without discoverable cause, and 6 went to term.

Two women were operated upon during labour. One was believed to be a case of extra-uterine gestation, but when the abdomen was opened the child was found to be in the uterus and a cyst occupying the pelvis. This could not be drawn up before it was tapped by the vagina and then the operation was successfully completed. In the second the operation was undertaken during labour under the following circumstances. The woman had had a large ovarian tumour, having jelly-like contents, removed about two years previously, and when next seen she was nine months pregnant and the subject of another large ovarian growth. The nature of the tumour was believed to be similar to that of the tumour previously removed, and it occupied the right side of the pelvic inlet pushing the head to the left iliac fossa. It was thought best to operate as soon as labour began, and this was done. Both patients made a good recovery and one child was born dead, the other lived.

The mortality consequent upon ovarian tumour complicating pregnancy is very great, and is only equalled in midwifery by that occurring in severe outbreaks of puerperal fever. Occasionally death takes place during pregnancy from rupture of the cyst, causing sudden death or setting up peritonitis, which leads to a fatal issue. I find five such cases, one in which suppuration of the cyst took place at an early period of pregnancy, bursting at the umbilicus and followed by death. The total number of deaths in the 461 pregnancies is 116, or 1 in 4, and it is a remarkable fact that the mortality in the easier cases was as large as in the more difficult ones, in cases which required little or no help as in those demanding the greatest skill. Of the 178 cases in which labour may be regarded as natural, 40 died, or almost 1 in 4. The causes of death in these are many. Death may occur suddenly in labour, or after delivery in the course of a few hours, days, weeks, or months, all due to the tumour and the accidents of labour complicated by it. The causes of death are hectic and suppuration, rupture and gangrene of the tumour, peritonitis

(a common cause, it was present in at least 11 of the cases), rupture of the cyst during labour in 6, gangrene in 2, sepsis in at least 4, probably in more; hæmorrhage into the cyst in one, and uterine hæmorrhage in one. It is not possible to distinguish in all cases between septic inflammation in this complication and inflammation due to other causes. At the same time an attack of acute inflammation of the tumour and peritoneum ending in suppuration of the cyst should be suspected of being septic in origin. It is clear, however, that a large number of the deaths were due to injury done to the tumour by the forces of labour and were unavoidable. One death was due to cancer and one to eclampsia. After reposition two deaths occurred, one of them being due to cancer. The number of deaths after tapping was 16, the number of cases tapped being 61—1 in 4. In 3 of them the tapping was followed by ovariotomy; it was followed by suppuration in 3; by peritonitis in 3 others, and by rupture in 1, so that tapping has proved a fruitful source of mischief.

After delivery by the forceps, 9 out of 36 died—1 in 4. Six of these died with peritonitis; in one the forceps proved unsuccessful and craniotomy was performed, and in one the cyst burst. Several of the cysts had been tapped before the employment of the forceps. After version, there were 7 deaths out of 21 cases. In one the uterus was ruptured, and in one the cyst. The cause of death in the others is not stated. Eleven deaths out of 25 cases followed craniotomy; in several of the cases tapping and the forceps had been resorted to before craniotomy. Abortion occurred spontaneously or was induced or caused by operative measures in 80 cases, and of these 14 died, the causes of death being in the majority peritonitis and rupture of the cyst. The 6 cases operated upon by the Cæsarean method all died except one. The operation was undertaken after death in one, and after 60 hours of labour in another. After ovariotomy 7 died out of 72. This is not greater mortality than that from ovariotomy generally apart from pregnancy. The causes of death were persistent vomiting, peritonitis, gangrene of the cyst, rupture of the cyst and intestinal obstruction. Abortion followed ovariotomy in 15 cases out of 51 operated upon. Ovariotomy was preceded by tapping in two cases, rupture of the cyst in one, and the introduction of the sound in one. Three women died undelivered.

Such is, then, the record as I make it of the results of pregnancy complicated by ovarian tumours. It is a record of a mortality which is appalling in childbed. Twenty-five per cent. is the mortality of all the cases good or bad taken together; it is the mortality in cases which demand no interference in order to effect delivery.

The mortality after			tapping is	...	...	26 per cent.[1]
,,	,,	,,	forceps is	...	...	25 ,, ,,
,,	,,	,,	version is	...	...	33 ,, ,,
,,	,,	,,	craniotomy is	...	...	44 ,, ,,
,,	,,	,,	abortion and premature labour is	...	...	17 ,, ,,
,,	,,	,,	Cæsarean section is	...		90 ,, ,,
,,	,,	,,	ovariotomy is	...	...	10 ,, ,,

Now the great mass of this mortality takes place after delivery. Comparatively few cases die during pregnancy when not interfered with. I find only one sudden death during pregnancy, believed to be due to rupture of the cyst; and 6 others apparently after delivery, premature or at term, in which the cyst burst during pregnancy. This forms 6 per cent. of the deaths; the remaining 109 follow operations on the tumour and delivery; and it is not possible to allot them to their different causes with the exception of 7 after ovariotomy. This leaves us 102 cases following labour and abortion.

When the mortality is so large as 25 per cent. in cases in which the tumour occasions no particular difficulty in delivery, it is evident that there is something besides the difficulty of the labour which tends to death; and this we must look for in the tumour, and the injury done to it, and by it, during the efforts of labour. We have shown that the tumour receives injury frequently, whether it be seated in the abdomen or in the pelvis, and it depends largely upon its nature and the character of its contents what the consequences of that injury may be. It is clear from the record of deaths that little can be done to diminish the danger by the usual obstetric operations, and it seems to me that we

[1] In a large number of the cases operated upon more than one operation was resorted to, such as tapping, forceps, craniotomy, and the same cases appear therefore under each of the operations.

must look for a diminution of the mortality from this complication in the resources of surgery; and that our efforts should be directed to the prevention of injury to the ovarian growth and the parts adjacent to it, abdominal and pelvic. At present I see but two ways in which this can be accomplished. One is the removal of the tumour during pregnancy or labour, and the other is the anticipation of labour by the Cæsarean section. By ovariotomy the tumour is removed and cannot be damaged during labour, while if the Cæsarean section be undertaken the woman is delivered and the forces of labour are not called into action and the tumour escapes injury. The important question is, which are the cases which should be subjected to one or other of these operations. Should all or only certain cases? I do not think that all cases should be treated in one of these ways, for small tumours, situated in the abdomen, or tumours situated in the pelvis, which can be raised up into and retained in the abdomen, do not appear to suffer much injury during labour. With this exception I think that all cases should be operated upon. It is true that the results of Cæsarean section have been disastrous, according to the record, but these cases were operated upon —before the antiseptic method of operating was known, and before the modern technique of Cæsarean section was introduced—at a time indeed when Cæsarean section was the most fatal of operations. Now the operation is far less formidable, and its mortality has been greatly reduced. I should, however, have recourse to it only in cases in which the removal of the tumour is found to be impossible, be it from adhesions deep down in the pelvis, to the uterus or for other cause.

On the other hand, ovariotomy during pregnancy is a tried operation, and it has proved as successful during pregnancy as apart from pregnancy, and it gives a mortality of less than half that from natural labour with ovarian tumour; and no other method of treatment has as yet given, nor does any promise, such good results.

THE VALUE AND SAFETY OF ABDOMINAL EXPLORATION IN OBSCURE CASES.

By Leonard A. Bidwell, F.R.C.S.
Senior Assistant Surgeon, West London Hospital.

My object in bringing this paper before you is to try to change the opinion of those physicians who still believe that an abdominal exploration is an almost necessarily fatal operation, and who consider that only cases in which the condition is absolutely hopeless should be handed over to the surgeon. If a physician only has experience of laparotomy in acute obstruction of some days' standing, I am not surprised that he is dissatisfied with the results; but it is hardly fair to blame the surgeon for the lack of success in such cases. In the following paper, however, I make no reference to operations for acute obstruction, nor to those for disease of the pelvic organs, and I bring before you a series of thirty laparotomies for chronic obstruction and for diseases of the stomach, liver, and kidneys. In these cases one death occurred, and that a case of gastro-enterostomy, on the tenth day, from bronchopneumonia.

I believe that peritonitis is still dreaded as a consequence of simple abdominal exploration. You will observe that it did not occur in any of these cases, and I myself consider that there should not be more fear of peritonitis after opening the abdomen than there should be of cellulitis after opening the subcutaneous tissue.

I have arranged these cases in tables, which are before you, and have grouped them into explorations for (*a*) chronic intestinal obstruction, and diseases of (*b*) stomach, (*c*) liver and (*d*) kidney.

In the first group are six cases, to which I will refer in detail; in four there were adhesions producing chronic obstruction; in one malignant disease of the transverse colon, and in one a perityphlitic abscess. All the cases made good recoveries.

In the second group there are nine cases: four were cases of cancer of the stomach, in three of which gastro-enterostomy was performed; one was a simple stricture of the pylorus; one a suspected gastric ulcer, and two were cases of gastros-

TABLE OF ABDOMINAL EXPLORATIONS.

A.—Exploration of Intestines.

No.	Date.	Case.	Sex.	Age.	Place.	Disease.	Operation.	Result.	Remarks.
1	Aug. 11, 1891	Miss H.	F.	40	Private	Abdominal Pain and Irregularity of Bowels	Abdominal Exploration	C.	Small Uterine Fibroid, which has since become much smaller. Adhesion of sigmoid.
2	Nov. 13, 1894	Mrs. W.	F.	47	Private	Pain and Diarrhœa...	Abdominal Exploration. Division of adhesions	C.	Transverse Colon adherent to Gall Bladder, causing a kink.
3	July 13, 1895	Mrs. D.	F.	41	W.L.H.	Chronic Obstruction	Abdominal Exploration. Division of adhesions	C.	An Uterine Fibroid had been removed by a *serre-nœud* three years before. Sigmoid adherent to uterus and kinked.
4	Feb. 24, 1896	A. B....	M.	33	W.L.H.	Pain and Diarrhœa alternating with Constipation	Abdominal Exploration. Division of adhesions	C.	Lump could be felt in region of the Cæcum. Coil of ileum adherent to brim of false pelvis near to cæcum.
5	Feb. 27, 1897	A. P....	M.	28	W.L.H.	Tumour in Abdomen. Chronic Obstruction	Abdominal Exploration. Transverse colotomy	C.	Carcinoma of Transverse Colon which was adherent to and infiltrated the pancreas. Excision impossible.
6	Aug. 22, 1894	A. C....	F.	16	W.L.H.	Tumour just to right of Umbilicus	Laparotomy. Subsequent incision of abscess and excision of appendix	C.	Abscess in connection with Appendicitis at level of Umbilicus, nothing in iliac fossa. Patient had history of gastric ulcer.—*Vide* W. L. Med. Journ., vol. ii., p. 51.

No.	Date.	Case.	Sex.	Age.	Place.	Disease.	Operation.	Result.	Remarks.
7	Aug. 8, 1893	Mr. D.	M.	60	Private	Carcinoma of Pylorus	Laparotomy and Gastro-jejunostomy	R.	Recovered perfectly from operation, but died six weeks later from exhaustion.—Vide *Trans. Clin. Soc.*, v.27,p.11.
8	Dec. 10, 1894	Mrs. C.	F.	31	W.L.H.	Carcinoma of Pylorus	Laparotomy and Gastro-jejunostomy	D.	Death on tenth day from Broncho-Pneumonia. Abdominal and stomach wounds soundly healed.
9	Jan. 3, 1897	Mrs. M.	F.	39	W.L.H.	Carcinoma of Pylorus	Laparotomy and Gastro-jejunostomy	C.	Stomach extended to within one inch of pubes. Small growth at pylorus. One week after operation stomach had retracted to one inch above the umbilicus. Two weeks later stomach percussion quite normal. Still alive and well.
10	Feb. 7, 1895	T. S....	M.	54	W.L.H.	Simple Stricture of Pylorus	Laparotomy and Loretta's Operation	C.	Stricture of Pylorus probably due to a Cicatricial Contraction. Pylorus dilated so as to admit three fingers. Completely free from pain for 18 months. Now some dilatation of stomach reappearing.
11	Jan. 30, 1895	D. B....	M.	60	W.L.H.	Carcinoma of Stomach	Laparotomy... ...	R.	Large mass of Cancer in Stomach involving Pylorus. Secondary growths in parietal peritoneum. Fluid in peritoneal cavity. Much relief to pain by operation. Date of death unknown.
12	Jan. 24, 1895	Mrs. M.	F.	53	W.L.H.	Carcinoma of Stomach and Peritoneum	Laparotomy... ...	R.	Dilatation of Stomach and Ascites. Masses of cancer in stomach, omentum and peritoneum. Marked relief by operation. Alive six months afterwards.
13	June 25, 1895	E. B....	F.	24	W.L.H.	? Colic	Laparotomy... ...	C.	Admitted in a state of collapse with Acute Abdominal Pain. Attending hospital for gastric ulcer, nothing found.
14	June 24, 1895	S.	M.	65	Fulham Union	Carcinoma of Œsophagus	Gastrostomy... ...	R.	Impermeable stricture of Œsophagus, two years' history. Operation in two stages. Gained flesh for a time, but died five weeks later from fibroid phthisis.
15	Feb. 5, 1896	C. G....	M.	56	W.L.H.	Carcinoma of Œsophagus	Gastrostomy... ...	R.	Impermeable stricture of Œsophagus 12½ in. from teeth. Operation in two stages. Gained flesh but died May 10, 1896, from empyema and broncho-pneumonia. Abscess outside growth which had burst into pleura. —Vide *B. M. J.*, Oct. 24, 1896.

TABLE OF ABDOMINAL EXPLORATIONS—*Continued.*

C.—EXPLORATION OF LIVER.

No.	Date.	Name.	Sex.	Age.	Place.	Disease.	Operation.	Result.	Remarks.
16	July 24, 1890	C. M...	M.	32	Private	Abscess of Liver ...	Laparotomy. Incision in two stages	R.	Patient completely recovered from the operation, and wound healed. He died, however, six weeks later from dysentery.—Vide *St. Thos. Hosp. Reports*, vol. 21, p. 209.
17	Aug. 2, 1892	S. G....	M.	35	W.L.H.	Abscess of Liver ...	Laparotomy. Incision of abscess in two stages	C.	Patient had been in India ten years previously, but not since.—*St. Thos. Hosp. Reports*, vol. 21, p. 209.
18	May 26, 1893	F. I....	M.	40	Private	Gall Stone Colic ...	Cholecystotomy ...	C.	No Gall Stones found, but Gall Bladder thickened, and Omentum adherent to it. Probably gall stones, which had been passed, had set up the inflammation. Perfect relief of symptoms.
19	Nov. 29, 1893	J. B. ...	M.	35	W.L.H.	Gall Stone Colic ...	Cholecystotomy ...	C.	Two hundred Gall Stones removed, the gall bladder being completely packed with stones.—Vide *Lancet*.
20	Aug. 3, 1894	Mrs. E.	F.	38	W.L.H.	Gall Stone Colic ...	Cholecystotomy ...	C.	Gall Bladder dilated and filled with Mucus. No stones, but adhesions about cystic duct. Gall bladder drained for a week. Complete relief.
21	Dec. 21, 1896	Mrs. R.	F.	35	W.L.H.	Gall Stone Colic ...	Cholecystotomy ...	C.	Thirty-six Gall Stones removed. No bile in gall bladder. One stone left in cystic duct, but bile flowed freely from the wound on fourth day, showing that passage was clear.
22	May 12, 1895	A. P....	F.	22	W.L.H.	? Gall Stone Colic ...	Exploration of Gall Bladder	C.	Tumour just below and almost continuous with Liver. History of colic. Gall bladder normal, but right kidney very movable. Nephorrhaphy performed.
23	Sept. 1, 1896	Mrs. T.	F.	41	W.L.H.	? Gall Stone Colic ...	Exploration of Gall Bladder	C.	Attack of Colic resembling Gall Stones. Jaundice, tumour felt below liver; dull on percussion. Gall bladder quite normal. Tumour proved to be enormously fatty omentum (about two inches thick). Relief of symptoms.

D.—Exploration of Kidney.

No.	Date.	Name.	Sex.	Age.	Place.	Disease.	Operation.	Result.	Remarks.
24	Aug. 12, 1892	Mrs. J.	F.	35	Private	Tuberculous Kidney	Exploration of Kidney	C.	Tumour consisted of Enlarged Kidney displaced downwards. Tubercle seen on surface. Nothing done. Relief of all symptoms.
25	June 14, 1893	E. B....	F.	48	W.L.H.	Cancer of Kidney ...	Exploration of Kidney Nephrectomy	C.	
26	Dec. 17, 1892	Mrs. P.	F.	49	W.L.H.	Hydro-nephrosis ...	Laparotomy. Exploration of Ureter for hydro-nephrosis	C.	Hydro-nephrosis drained six months before. Purulent Renal Fistula. Ureter explored by incision in linea semi-lunaris. Nothing found, so lumbar nephrectomy performed.
27	Oct. 28, 1893	Mrs. H.	F.	32	W.L.H.	Pyo-nephrosis ...	Exploration of Kidney	R.	Calculous Pyelitis. Six Calculi removed. Subsequent successful nephrectomy.
28	July 12, 1895	Mrs. R.	F.	41	W.L.H.	Hydro-nephrosis ...	Exploration of Kidney Nephrectomy	C.	
29	June 17, 1893	S. S....	F.	57	W.L.H.	Hydro-nephrosis ...	Exploration of Kidney Nephrectomy	C.	
30	Jan. 2, 1896	Miss B.	F.	27	Private	Hydro-nephrosis ...	Exploration of Kidney Nephrectomy	C.	

tomy for cancer of the œsophagus. One case died ten days after the operation of gastro-enterostomy, from broncho-pneumonia. Probably her death was accelerated by the ether given at the operation. All the other cases made good recoveries.

In the third group we have eight cases—two abscesses of liver, four cholecystotomies and two explorations for hepatic colic, in which the gall bladder was not opened. All the cases made good recoveries.

In the fourth group are seven cases, five of which were nephrectomies—one for carcinoma of kidney, three for hydronephrosis, one for calculous pyo-nephrosis—one an examination of tubercular kidney, and one an exploration of ureter after drainage of a hydronephrosis. All the cases made good recoveries.

It is to the group first described that I wish especially to refer, and I propose to give short notes of some of them.

CASE 1 (No. 1 on list).—Miss H., aged 40 years, consulted me in July, 1891, on account of hæmorrhoids, for which a Whitehead's operation was done. She had not been able to get about for nearly a year on account of abdominal pain, and the bowels were irregular. Nothing could be felt by abdominal palpation, and a laparotomy was suggested and accepted by the patient.

August 11, 1892.—The patient was put under chloroform, and the abdomen opened in the middle line. There was a small fibroid tumour in the body of the uterus, and the organ was displaced to the left and the sigmoid was adherent near to it. The adhesions were divided and the abdominal wound closed.

The patient made a complete recovery, and has not had any return of her abdominal pain.

CASE 2 (No. 2 on list).—Mrs. W., aged 47, came under my care in October, 1894. For five or six years she had suffered from attacks of pain and occasional swelling in the right hypochondrium. The attacks of pain came on about 4 a.m. each morning; it was a hot griping sensation and lasted sometimes for hours, and was followed by diarrhœa, after which the pain left her. These attacks of pain used to occur at first two or three times a week, but afterwards every morning, and were worse in the autumn and better in

the summer; they were worse after moving about and after any excitement.

She had never passed a gall stone, but had jaundice twenty years before, and occasionally got yellow after an attack of pain, especially after the first attack six years ago. The bowels used to be confined between the attacks, but afterwards were always loose; occasional melæna. She had been under special diet, and had been taking saccharated carbonate of lime for two years.

On examination the abdomen was not distended; there was an increased sense of resistance in the right hypochondriac region, but the liver dulness was not increased. There evidently was some enlargement in the region of the gall bladder, and from this a hard cord-like swelling could be traced downwards along the posterior border of the right rectus half way to the umbilicus. There was a slight icteric tinge of the conjunctivæ, and the patient was rather thin. There was no stricture felt per rectum. The patient was kept under observation for some days, and when she was kept in bed the attacks of pain decreased in frequency but returned when she was allowed to get up. The motions were searched for gall stones without result.

After consultation with Dr. Nestor Tirard, we agreed that the symptoms pointed to stricture of intestine from adhesion to the gall bladder, with probably cholelithiasis, so an exploratory operation was recommended.

November 13, 1894.—The patient was put under ether and an incision about three inches in length made in the upper part of the right linea semilunaris above the umbilicus. The liver was prolapsed, having descended to about three inches below the ribs. The gall bladder was filled with bile but was easily emptied by pressure. The transverse colon and the great omentum were adherent to the gall bladder along the whole of its under surface. These adhesions were divided and all bleeding points ligatured. The adhesions had caused a kink in the transverse colon, but the gut appeared healthy and there was no stricture. The common bile duct was explored but no stone was felt. The abdominal wound was closed with silkworm gut sutures.

The patient made a rapid and perfect recovery from the operation, and has not had any of the attacks of abdominal

pain since the operation. She returned home on December 1. When last heard of six months ago she was in good health, had gained flesh, and was never troubled with irregularity of the bowels.

CASE 3 (No. 3 on list).—Mrs. D., aged 37, was sent to me at the West London Hospital by Dr. Clarke Wakefield. Three years previously she had undergone laparotomy and removal of some subperitoneal fibroids by means of the *écraseur*. Eighteen months after this operation the patient began to suffer from constipation and abdominal pain. During the four months before admission the difficulty with the bowels became worse and she passed blood and mucus with her motions.

On examination there was some abdominal distension and pain on pressure in the left iliac region. A fibroid of the uterus could still be felt.

The abdomen was reopened and the sigmoid flexure found to be intimately adherent to the stump of the uterine fibroid. A number of bands were also found passing between the great omentum and the tumour. The sigmoid was freed from its adhesions, and the omental bands were divided between ligatures. The fibroid tumour was removed at the same time with the knife, after the formation of the peritoneal flaps. The patient made a good recovery and lost her abdominal pain.

CASE 4 (No. 4 on list).—A. B., aged 33, was admitted into the West London Hospital under Dr. Ball, on February 23, 1896. Three days before admission he had an attack of abdominal pain and diarrhœa, accompanied by the passage of mucus, and tenesmus. Considerable fulness could be felt in the right iliac region, and the abdomen was slightly distended.

On admission the abdominal pain continued and fulness could still be felt, though the diarrhœa had ceased. The swelling and sudden onset of the symptoms rather favoured the view of intussusception, so an exploratory operation was decided on.

On February 24 the abdomen was opened in the right linea semilunaris below the umbilicus, and the swelling explored. It was found to be due to a distended coil of ileum, which was attached at its convexity to the fascia over

the iliacus, and so produced a kink which caused the obstruction. The adhesions were separated, and though the cæcum was examined the vermiform appendix was not found. The patient made a perfect recovery and did not have any return of his abdominal pain.

It is probable that the adhesion in this case was due to old appendix trouble, but no history of such a condition was obtainable.

In all these cases, although the symptoms were rather indefinite and different in each case, some definite trouble was found on opening the abdomen. The adhesions in each case were evidently the cause of the symptoms of abdominal pain and irregularity of bowels, and so the operation was justified. We must remember, however, that adhesions, besides causing these sypmtoms, also may at any time cause acute strangulation, either by catching another knuckle of intestine or by twisting; so a patient's life is in constant danger unless the adhesions are divided. I have recorded in the *British Medical Journal*[1] two cases in which acute obstruction occurred in consequence of adhesions, caused in one case by a previous ovariotomy, and in the second by some puerperal perimetritis. Both were treated successfully by laparotomy, although in the second case primary resection of gut was necessitated.

I was first impressed with the importance of early abdominal exploration in cases of abdominal pain and irregularity of bowels by remembrance of the following case, which I saw with my friend Dr. Walter Edmunds, and which he reported to the Clinical Society. A man aged 54 years, for six months before admission had suffered from pain in the lower part of the abdomen and from some constipation, to which he had not previously been subject. Three weeks before admission he had some intestinal obstruction which did not yield to treatment for twelve days. When first seen he had only slight abdominal fulness, but no tumour could be felt either by abdominal examination or per rectum. However, an abdominal exploration was performed, and a circular growth was found at the lower end of the sigmoid flexure. The piece of gut was excised and an artificial anus left, which was closed after a lateral anastomosis had been made. The growth was typical carcinoma, and the patient lived over

[1] *Brit. Med. Jour.*, May 8, 1897, p. 1151.

three years after the operation. If we are to do any good in cases of intestinal cancer, it is absolutely necessary that we diagnose the case early, and an early diagnosis can be made only by abdominal exploration. If we leave the case till acute or even sub-acute obstruction takes place, we cannot hope to perform a radical operation successfully, although in sub-acute cases I believe that removal of the stricture is preferable to performing a colotomy in the stages.

Another group of cases to which I would draw attention is that of two cases of diffused peritoneal cancer, which were greatly benefited by simple opening of the abdomen. In the following cases all the abdominal pain was lost, and the patients expressed themselves to be much benefited by the operation.

CASE 1 (No. 11 on list).—D. B., aged 67 years, was admitted with abdominal distension, pain in the hypochondriac and epigrastric regions, and vomiting. The stomach was dilated to below the umbilicus. An incision was made above the umbilicus and a pint of yellowish clear fluid escaped. A large growth was found at pylorus, and secondary growths in the bowel and parietal peritoneum. The stomach was not greatly dilated. The wound was closed. There was great improvement in the patient's condition, the sickness almost disappeared and he took food much better. He got up fourteen days after the operation, and was discharged fourteen days later. The later history of case is unknown.

CASE 2 (No. 12 on list).—Mrs. M., aged 53, was admitted into the hospital on June 20, 1895, under Dr. Ball. She had enjoyed good health till one year previously, when she began to feel weak and had wasted since. Five months before admission she began to notice pain in the lower part of the abdomen, and for three months the pain had been chiefly in the epigastric and right hypochondriac regions. The pain was not affected by food, and there was only occasional vomiting. The bowels were regular. On examination the abdomen was distended, and free fluid could be detected in the peritoneal cavity. A hard mass could be felt to the right of the umbilicus.

On June 24, 1895, the abdomen was opened in the middle line above the umbilicus and a quantity of clear serous fluid escaped. The gall bladder and pylorus were explored, both

of which were found to be healthy, but the liver was enlarged and some secondary cancerous growths were seen on its surface. A large mass of malignant disease was felt in the region of the cæcum, and numerous secondary growths in the peritoneum and omentum. The abdomen was closed without any further operation, and the patient made a good recovery, being discharged from the hospital three weeks after the operation. She lost all her abdominal pain, and there was no recollection of ascitic fluid for three months. She also regained some of her lost weight. She attended as an out-patient for six months, but was then lost sight of. There is no question that the operation checked the growth for a time at least, and gave complete relief to her pain.

A third group of cases to which I would refer, is that of four operations for pyloric obstruction. As these cases are published more or less in detail elsewhere,[1] I will not enter into details. In three cases the operation of gastro-enterostomy was performed, the anastomosis being effected by stitches alone, according to Halsted's method of lateral anastomosis.

In the first case (No. 7 on list) the patient, a gentleman, aged 69, lived for six weeks after the operation during which time he was in comparative comfort on account of the relief given to the dilatation of his stomach by the anastomosis.

In the second case, of a woman aged 31 years (No. 8 on list), although the anastomosis was perfect, and the dilatation of the stomach relieved, the patient died ten days after the operation from broncho-pneumonia. At the *post-mortem* the anastomosis was found to be perfectly united, and there was no trace of any peritonitis.

In the third case, a woman aged 39 years (No. 9 on list), the stomach was enormously dilated, reaching to within an inch of the pubes. A week after gastro-enterostomy the stomach did not extend to more than one inch below the umbilicus, and before her discharge from the hospital it was practically normal. All her symptoms of stomach dilatation have disappeared, she has gained flesh, and is still in good health, now more than four months after the operation.

The fourth case was an example of Loretta's operation, in which the pylorus is digitally dilated, through an incision

[1] *Med. Times and Hosp. Gaz.*, Feb. 13, 1897, p. 99.

made in the anterior wall of the stomach. In this case (No. 10 on list) a man aged 54 years had dilatation of stomach and a hard tumour in the region of the pylorus. After opening the abdomen the stomach was explored, and as the pyloric stenosis did not appear to be due to malignant disease, an incision was made in the anterior wall of the stomach, and the pylorus dilated with the finger until three fingers could pass easily through the aperture. The patient made a perfect recovery, and lost all his dyspeptic symptoms. It is now more than two years since the operation, and for eighteen months he had no return of his symptoms; within the last six months, however, the stomach has been commencing to dilate again, and I have been considering the question of a further operation, but have postponed the question as the patient does not have much pain or inconvenience at present.

While considering the benefits conferred by the operation of gastro-enterostomy, I would like to refer to a case recently communicated to the Clinical Society by Mr. E. Lane. In this case the patient is still alive and free from her symptoms, two and a half years after the operation.

I think that all will admit that the three last cases of pyloric obstruction have been considerably benefited by surgical means, and I am quite sure that they themselves will say so. However, operations for pyloric obstruction are not at all favoured by physicians, and although this condition is only too common, it is extremely rare that such a case is handed over to a surgeon. I believe that the cause of this hesitation on the physician's part is a fear that the operation may prove fatal, but this fear really need not exist, since the operation is one of the least fatal in abdominal surgery—in fact one surgeon (Mr. Lebove) has published a series of twenty-two consecutive cases without a death.

In conclusion, I would like to draw your attention to the ease with which kidney trouble on the one hand, and pyloric trouble on the other hand, can be confused with gall bladder mischief, and I must admit that I have, on more than one occasion, operated expecting to find some gall bladder trouble, and have found one of these two conditions.

Considering the difficulty of diagnosis, not only in such cases, but practically in all abdominal cases, I urge the value

of abdominal exploration, and I hope that the tables which are annexed will convince you that this procedure is a safe one.

THE PATHOLOGY AND TREATMENT OF EMPHYSEMA.

By Harry Campbell, M.D., F.R.C.P.

I cannot deal in this paper with all the aspects of emphysema. I shall confine myself to a consideration of the important part which loss of pulmonary elasticity plays in its pathology, and shall attempt to show how a proper recognition of the fact furnishes a clue to the treatment of the disease.

In a typical instance of large-lunged emphysema, the thorax is in a condition of super-extraordinary inspiration. How are we to account for this enormous thoracic expansion? It cannot be caused, as one is so apt to assume, by the lungs thrusting the chest walls outwards, seeing that these organs exercise a suction action upon them. It is true that in emphysema this suction is lessened, and may in advanced cases even be absent; but it is probable that emphysematous lungs never habitually exert a positive pressure upon the interior of the chest.

Another view—that of Freund—assigns the chest expansion to overgrowth of the ribs and sternum, whereby these structures are altered in shape and position; but there can be little doubt that these changes are secondary to thoracic expansion, and not the cause of it.

I hold that two essential factors contribute to the enlargement of the chest in hypertrophous emphysema: defective pulmonary elasticity and dyspnœa. In consequence of the former, the suction action of the lungs is diminished, and the thoracic elevators being no longer properly antagonised, gain the upper hand, and expand the chest, which may thus go on enlarging for many years before any decided symptoms develop, and before the individual has any notion but that his lungs are perfectly normal. Sooner or later, however, dyspnœa supervenes, and inasmuch as this excites the inspiratory more than the expiratory muscles, there is now a

still greater preponderance of the expanding over the contracting forces. Now this protracted over-action of the thoracic elevators in course of time leads to their hypertrophy and contracture, *i.e.*, permanent shortening—exactly in the same way as in talipes. In consequence of this contracture the thorax is fixed in the inspiratory position, the fixation being also favoured by changes in the thoracic bones and joints resulting from the defective costal mobility. That the thoracic elevators undergo marked hypertrophy and contracture in hypertrophous emphysema is evident from an examination of the cervical muscles in old-standing cases of this disease; not only do they stand out prominently, but they may be felt to be hard and tense, and when we reflect how greatly the clavicles are raised, it is evident that these muscles must become permanently shortened.

I do not overlook the fact that the expiratory muscles are also brought into forcible play in emphysema. This, of course, tends to retard the process of expansion, but does not prevent it, because the inspiratory forces preponderate over the expiratory.

The degree to which the chest expands in emphysema is greatly influenced by the extent of its mobility at the onset of the disease, and also by the vigour and activity of the muscle system. The more mobile the chest and the more muscular the individual, the greater the expansion. When the disorder starts in old age, when the chest is rigid and the muscles are feeble, little expansion occurs.

The process of thoracic expansion in hypertrophous emphysema is to large extent injurious; it leads to a continuous stretching of the alveoli, and thus not only diminishes their elasticity, but very seriously interferes with their nutrition, a fact well shown by what happens in compensatory emphysema. It therefore follows that *mere loss of pulmonary elasticity by inducing thoracic expansion, is sufficient to bring about emphysema.*

The progressive enlargement of the chest in emphysema has a further injurious effect, in that it tends to produce fixation of the chest *and thus to diminish the expiratory range.* This is one of the worst aspects of emphysema, and has not received the attention it deserves. The diminution in respiratory area is serious enough, but this would be largely compensated for if only the patient could adequately expire. The breathless-

ness is far more due to the meagreness of the tidal current than to the limitation of the respiratory surface.

No satisfactory explanation has hitherto been given of this diminished expiratory range. Loss of pulmonary elasticity, while accounting for defective expiration when unaided by muscular effort, cannot account for the patient's inability to empty his lungs by means of the most violent expiratory effort. Nor can we account for it by assuming that some expedient to the expiratory current is present in the air passages, seeing that air can be expressed from the lungs by the thrusting upwards of the diaphragm by abdominal contraction. I have little doubt that the diminished expiratory power is due to the fixity of the chest, brought about in the manner described, *i.e.*, essentially by contraction of the thoracic elevators just in the same way as the foot is fixed in an abnormal position, and its movements limited, by the contraction of certain muscles.

Treatment.

From the foregoing observations it is manifest that in the treatment of emphysema we should seek (*a*) to preserve the elasticity of the lungs, and (*b*) to prevent overaction of the costal elevators, so as to check thoracic expansion, and (*c*) to maintain the normal mobility of the thorax.

(*a*) Loss of pulmonary elasticity comes on with age, and much more rapidly in some than others. Thus some may be much more senile in this respect at 50 than others at 70. It results from all structural diseases of the lungs, such as bronchitis, pneumonia, and phthisis, and it is diminished by fever, phosphorous poisoning, and many other conditions. There remains one important cause, namely, overstretching of the alveoli. This may result from increased intra-alveolar tension, such as occurs in the effort of coughing, defæcation, blowing wind instruments, or lifting heavy weights with closed glottis; or it may result from compensatory dilatation, as happens when a part of the lung is destroyed or prevented from expanding, or when the thorax is unduly expanded, be it from loss of pulmonary elasticity or from the inspiratory efforts of dyspnœa, or spasmodic asthma.

Wherefore, in order to preserve pulmonary elasticity, we should endeavour to check the advent of premature senility

by causing the individual to lead a healthy and temperate life. The lungs should be carefully sheltered from bronchitis, pneumonia, and other diseases. Cough, blowing wind instruments, and all muscular exercises with fixed thorax should be avoided; and special care should be taken to guard against that over-distension of the thorax to which allusion has been made.

(b) In order to prevent overaction of the inspiratory muscles, and thus to check thoracic expansion, the patient must guard against all causes likely to induce dyspnœa, which, as we have seen, excites the inspiratory muscles more than the expiratory. Hence such exercises as running upstairs and mountain-climbing should be avoided. We should further seek to antagonise the inspiratory muscles by calling the expiratory into play. From the earliest phase of the disease recourse should be had to expiratory exercises. Thoracic expansion begins long before the recognised signs of emphysema show themselves, and it is in this early phase of the disease that the expiratory exercises should be begun. Unhappily the patient does not often come under the physician's notice for emphysema until the disease has made considerable progress, but it may frequently be observed when he is consulted for some other conditions.

The expiratory exercises I adopt are very simple. They consist of the deepest possible expirations. Starting from the position of ordinary inspiration the patient should expire to the utmost with mouth wide open, the body being bent forward the while, so as to favour compression of the diaphragm from below. These exercises should be practised for at least half an hour twice daily. Special exercises of the abdominal muscles should also be resorted to. Thus the patient lying supine is directed to raise his body, the legs being held by an assistant if necessary. In this way the great depressors of the thorax may be considerably developed. Retraction of the belly, by which the transversalis is exercised, should be frequently practised, and thus the tendency to undue opening-out of the costal arch prevented. Massage and faradisation of the abdominal muscles may in some cases be called for.

Apart altogether from the advantage gained in thus antagonising the inspiratory muscles, it is of great advantage to the emphysematous patient to have firm and well-developed

abdominal muscles, since a lax state of these muscles predisposes to many evils which tell against him, such as flatulence, costiveness, dislocation of the abdominal viscera, as Mr. Bruce Clarke has so well shown, and the accumulation of blood in the portal area.

(*c*) By means of the expiratory exercises just described we may also check the tendency to fixation of the thorax; indeed, we can generally increase thoracic mobility considerably in this way. Defective thoracic mobility in an apparently healthy man is always suggestive of commencing emphysema. Here the use of the spirometer comes in. If we find a man of 40, with no apparent lung disease, to have a chest measurement of 38 inches, and a vital capacity of only 220 cubic inches, we may be pretty sure he is on the road to emphysema. Let us never forget that thoracic girth is no guide to pulmonary efficiency. The spirometer often shows a chest of 34 inches to have a greater inlet capacity than one of 40 inches. Another valuable sign of early emphysema may be mentioned. Normally expiratory force is decidedly greater than inspiratory. Now Waldenburgurg has shown that the reverse is the case in emphysema, in which disease inspiratory force may be three times more powerful than expiratory force.

When the chest is very fixed it may be necessary to resort to special means to favour the expiratory movement. Some help may be got by massage of the chest walls and of the various thoracic joints. External compression of the thorax during expiration is still more useful. Breathing into a chamber of rarefied air, while the expiratory effort is made, is also useful, since this tends to suck the chest walls inwards. On the other hand the emphysematous patient is undoubtedly benefited by inhaling condensed air, since this promotes respiratory interchange, and thus diminishes the dyspnœa, which is so injurious in emphysema.

By the treatment briefly set forth in this paper much good can certainly be done both in preventing and relieving emphysema. Its chief drawback is getting the patient to persevere in it for a long time. It involves a considerable sacrifice of time, and is apt to grow irksome, but few good results can be obtained without trouble, and certainly the results achieved in this instance are worthy the pains they cost.

THE PRINCIPLE OF "ANTICIPATORY" IN GLAND-EXCISION IN CANCER-SURGERY.

By Herbert Snow, M.D.Lond.

Surgeon to the Cancer Hospital.

Definition.

I have ventured to coin the term "Anticipatory" excision in order to designate the surgical removal of lymph-glands lying in the infection path of a carcinoma or epithelioma before these have undergone appreciable increase in bulk, although the clinical history of the particular case makes us more or less certain that secondary deposit must be already established therein.

This procedure involves no showy operative details, and I presume to bring it under the notice of the Society merely as a simple measure of common-sense precaution; yet of the highest value in appropriate cases; it is, I fear, too often neglected by those who are able to deal with the lesions in an early stage, an opportunity which relatively seldom falls to my own lot. The tissues or organs most commonly in question are the mamma, tongue, lips, mouth-cavity.

Course of Gland-Infection.

It is, perhaps, hardly necessary to remark that the phenomena of gland-infection by carcinoma or epithelioma (clinically two widely distinct species of malignant growth, though it is the unfortunate pathological fashion to confound them under the former title) show a conservative effort of Nature to restrict the diffusion of the disease. The lymph-gland is a sort of filter or D-trap, wherein the cell-particles are caught, otherwise they would at once reach the blood-current and be deposited all over the body. In the meshes of the gland they are retained, and almost without doubt the first to arrive are destroyed. Eventually they gain the mastery and proliferate, passing through three early stages of growth:—

(*a*) Insidious cell-growth, without any symptom whatever.

(*b*) Tenderness on pressure, without enlargement.

(*c*) Enlargement.

It is of practical importance to tabulate these three periods,

I think, because each of the two first occupies a prolonged period of time—two or three weeks at the very least.

The particular group or chain first infected is always constant and regular; as is also the time within which metastasis takes place. I will technically refer to the former as the "infection path," the latter as the "time-limit."

Thus the "infection-path" pursued by mammary carcinoma arising in the outer two-thirds of the organ lies, as every one knows, along the axillary lymph-glands to the sub-pectoral chain, thence to the mediastinal and supra-clavicular. It is not, however, I think, universally realised that deposit in the mediastina takes place simultaneously with that above the clavicle; so that no lasting benefit, in any case, I have myself dealt with, or have heard of in the practice of others, has ever followed removal of the glands above the clavicle.

And another point not duly recognised in the average text-book is that in carcinoma of the inner one-third, the sternal portion of the mamma, the cell-particles pass first to the thymus, with the adjacent lymph-glands of the anterior mediastinum, and only secondarily implicate the axilla. So that in the first place axillary gland-enlargement does not appear till several months later than in disease of the outer parts of the breast; and, secondly, clearance of the axilla is of relatively little avail in a well-established case of disease.

Then the time-limit, within which secondary deposit becomes established, rarely exceeds twelve weeks, and ordinarily averages six, an exception, of course, being made for the class of cases known as the "atrophic."

Epithelioma of the lips, of the anterior two-thirds of the tongue, with the adjoining buccal and alveolar tract, primarily attacks the *submaxillary* lymph-glands just anterior to the salivary gland of the same name; and, secondarily, the *mylo-hyoid* gland in the mesial line.

The time-limit of infection here varies very considerably between the two chief regional sites above indicated, although the disease is identical. Lip-epithelioma ordinarily attacks the glands within six months, and not till the lapse of three; epithelioma of the tongue hardly ever permits immunity longer than six weeks, being, indeed, one of the most rapidly infective varieties known.

Epithelioma of the posterior third of the tongue first infects

the superficial cervical lymph-glands, midway between the angle of the lower jaw and the sterno-mastoid, *i.e.*, in average instances. But lesions at the root of the organ, immediately adjoining the faucial pillars, attack the deep cervical almost simultaneously with the superficial.

These deep cervical glands are also infected primarily by lesions of the tonsil and pharynx. The *parotid* lymph-glands by lesions of the orbital and temporal regions. The *brachial* by superficial disease on the flexor aspect of the forearm; the dorsal lymphatics passing directly to the axilla.

In the lower extremity, the *superficial inguinal* glands form the infection-path of epitheliomata on the vulva, scrotum, penis, and margin skin of foot and leg; those around the *saphenous* opening enlarging almost simultaneously in disease of the scrotum, vulva, or perinæum. Here, however, the clinical course is remarkably tardy; enlargement commonly does not take place for a year, and then advances very gradually.

For this reason, and also because their removal lays bare a tract of fatty tissue in a region not easy to keep aseptic, actual gland-enlargements of course in stout patients are often unrecognised until the organs are exposed by dissection—a further argument for routine gland-excision. Interference with these glands is to be deprecated until there is some increase in bulk; although I see that Koblanck (*Centralb. f. Gynäk.*, 9, 1897) has recently advocated an extensive dissection. Cases of melanotic disease constitute an exception.

Procedure.

On the well-worn subject of axillary evacuation little need be said, except again to note the reservation above, upon carcinomata at the external edge of the mamma. Further, I would remark that the glands to whose removal special attention should be devoted are (*a*) those lying upon the axillary vein, which at a later stage, by means of their lymphatic vessels, enclosed the vessel within a rigid ring of cancerous tissue, thus causing the familiar "brawny œdema;" and (*b*) the chain on the under-surface of the pectoral muscles leading up to the clavicle. Should the operator rest satisfied with the book-rule of dissecting along the edge of the axillary vein, and removing only the tissues exposed to view when the arm

is held above the shoulder, these will probably escape. The sub-pectoral chain, like little pins' heads, can usually be scraped off without division of the muscles; though it is necessary, in advanced cases, to cut through the pectorales, subsequently suturing the divided ends with catgut.

Removal of the non-enlarged submaxillary lymph-glands is effected by a 2-inch submental incision down upon the anterior edge of the similarly-designated salivary gland. The latter should never be interfered with; it is not implicated, except in late stages, by direct infiltration, and in the dissection, the really dangerous lymph-glands will probably escape. The edge in question must be taken as guide; the peccant glands, three in number, are easily found when it is reached, lying in the retracted flap, subcutaneous, upon and not under the bone.

By slightly prolonging the incision, the *mylo-hyoid* gland, midway between the symphysis and the hyoid bone, is readily reached. As I have several times met with "recurrence" in this little gland after perfect clearance elsewhere, I now endeavour always to secure it also.

In unilateral epithelioma of the lower lip, tongue, or mouth-floor, the submaxillary lymph-glands on the corresponding side only need removal; *i.e.*, in the pre-enlargement stage. In central lesions, those on both.

Extraction of the clavicle glands will be effected by incision as for ligature of the external carotid. There is one deep gland exactly within the angle of junction of the facial veins with the internal jugular, which needs special attention.

Exception.

In cases of true "sarcoma," wherever situate, "anticipatory" excision is valueless. The glands are not implicated at all unless there is either infiltration by contiguity, or else general dissemination by the blood. If then in true sarcoma we find enlarged glands, we know that as a matter of course there is concurrent deposit in the viscera; and we proceed to their removal only as a measure of palliation.

I cannot forbear remarking that our professional pathologists, instead of searching for peculiarly hypothetical microbes in cancer, would do far better to turn their attention towards this noteworthy problem—the action of lymph-gland parenchyma upon malignant cell-particles, and explain to us

why some of the latter so freely grow and flourish there, while others, not appreciably differing in virulence, are so quickly destroyed there *ab initio;* or why *relative distance* and *site* have so marked an influence towards delaying or accelerating the development of cell-germs from different examples of perfectly identical cancer-species.

Cases.

Time permits reference to but a few cases, and those of such a nature as ordinarily prove specially intractable, recurring as a rule rapidly, and passing quickly towards a fatal result. I do not propose to refer to operations on the breast or lips.

Case 1.—*Tongue-Epithelioma.*—George P., 45, publican. In June, 1886, a typical epitheliomatous infiltration, 1 inch across, of three months' duration, on right border of tongue, ½ inch from tip; lancinating pain, elevated everted edges, surrounding induration, and all the usual symptoms. No gland enlargement felt. Excision of half tongue, with the corresponding submaxillary lymph and salivary glands (removal of the latter is never now practised). The patient last seen free from any trace of disease on February 8, 1896. (Immunity, nearly 10 years.)

Case 2.—*Tongue-Epithelioma.*—Mrs. G., 60. In April, 1886, small epitheliomatous sore, size of sixpence, of four months' duration, at right edge of tongue. Lancinating pain, darting into ear, indurated margins, &c. No gland enlargement. Excision with Paquelin's cautery, of infiltrated tissue only, and same procedure on glands as in preceding. Patient last heard of free from recurrence, January, 1890.

Case 3.—*Recurrent Tongue-Epithelioma.*—Alfred S., 45. After excision of part of left half-tongue at general hospital, a recurrent infiltration of portion remaining to left of raphé in April, 1890. Incipient enlargement of lymph-glands on both sides. Removal of entire tongue and glands. The man free from further recurrence, and working as agricultural labourer in May, 1896.

Case 4.—*Recurrent Tongue-Epithelioma.*—Donald E., 50, in January, 1893, had a strawberry-like papilloma, as large as a cherry, on dorsum of tongue, ¼ inch from tip. The anterior third of tongue excised, but the glands untouched, as the growth was apparently still in the pre-cancerous stage. In

September, 1894, a typical epithelial ulcer at right edge of cicatrix, and incipient enlargement of both cervical and submaxillary lymph-glands on same side. The man last seen free from any trace of disease, September, 1896.

CASE 5.—*Tongue-Epithelioma.*—Mary S., 52. In October, 1894, prominent, livid, epithelioma of 21 months—stated duration—1 inch in diameter, far back at right edge of tongue. The submaxillary lymph-glands not affected; two superficial cervical felt as large peas. Excision of whole tongue and of the glands in question, the submaxillary not being touched. The patient remained well until June of this year, when a small recurrent deposit appeared at the junction of the frænum with the gum, and was excised with part of the adjoining bone. She has since remained well. There has been no recurrence in the lymph-glands, cervical or other.

CASE 6.—*Tongue Epithelioma.*—Mrs. S., 55. In November, 1894, oblong prominent epithelioma to left of frænum, on under surface of tongue, and adjoining floor of mouth. Stated duration, one month. No gland enlargement. The anterior third of the tongue, the infiltrated tissues on buccal floor, and the non-enlarged submaxillary lymph-glands were excised. The patient unfortunately resumed the set of false teeth, to friction by which the lesion had been produced. After several attacks of aphthous ulceration an indurated painful sore was again found in June of present year, and was promptly excised with Paquelin's cautery; since when there has been no further trouble. There has been no gland recurrence at any time.

CASE 7.—*Tongue Epithelioma.*—Edward F., 65. In March, 1891, a prominent fungating ulcer, ½ inch in diameter, of two and half months' duration, on left edge of tongue. No gland enlargement, but tenderness on pressure. Removal of whole tongue, and of left submaxillary lymph-glands. Seen well, with no indication of recurrence, November 30, 1896. (Nearly 6 years' immunity.)

CASE 8.—*Epithelioma of Buccal Floor.*—Joseph F., 44. In October, 1892, a small epithelioma of the frænum linguæ, adherent to the gum, of eight weeks' duration. A right submaxillary lymph-gland, felt as large as a bean, ditto on left, just perceptible to touch. Free excision of lower part of tongue, of lymph-glands on both sides, and of infiltrated mouth-floor. The adjoining periosteum was also freely cau-

terised. In February, 1893, the mylo-hyoid gland was found in size that of a large pea, and promptly removed. Patient last seen perfectly well, January 18, 1897.

Mylo-Hyoid Recurrence.

The two examples following further indicate the importance of the little mylo-hyoid gland in these conditions. The infection does not, I think, commonly take place until the lymph-current is diverted by the operation from its normal course, first to the submaxillary, next to the cervical lymph-glands.

Case 9.—Charlotte H., 47. In September, 1895, epithelioma of eight months' duration, on left side of tongue, ½ inch from tip. Two enlarged submaxillary glands, size of horse-bean. Removal of these, with anterior third of tongue. In June, 1896, the mylo-hyoid gland felt as large pea, and excised; no further recurrence to present time.

Case 10.—George W., 55, pensioner. In July, 1895, to right of frænum, typical epitheliomatous sore, of nine months' duration, size of sixpence, with gland of size of bean under lower jaw. Excision of these. In January, 1896, mylo-hyoid gland, size of bean; other tissues healthy. The latter removed, and no further trouble up to date.

Conclusion.

No operation for carcinoma or epithelioma in their earlier stages should be undertaken without the intelligent appreciation of the above principle, involving a trivial addition to the ordinary *technique* of care and trouble, but none of danger; whereas it confers an almost absolute guarantee of radical cure. The old rule-of-thumb method of dissecting out only the palpable tumour, and not touching the dangerous glands unless enlarged, is an anachronism unworthy of the nineteenth century, and mainly answerable for the public distrust of cancer-surgery. With greater attention at the schools to the anatomy and mechanism of the lymphatic system, the principle of "anticipatory" excision will be found susceptible of further extension than that indicated in the preceding imperfect sketch.

Report of Proceedings.

Ordinary Meeting—April 2, 1897.

Dr. J. L. W. THUDICHUM, ex-President, in the Chair.

The Serum Diagnosis of Typhoid Fever.

Dr. A. M. GOSSAGE read a paper under this title, which will be published *in extenso* in the October number of the JOURNAL.

The Pathology and Treatment of Emphysema.

A paper was read upon the above subject by Dr. Harry Campbell, which is published on page 177.

The following discussion then ensued:—

Dr. THUDICHUM: Emphysema of the lungs is more commonly a symptomatic result than an idiopathic condition. Whatever structural opportunities certain lungs may afford for its origination its cause is mechanical, namely, an expansion of the membranes of the air vessels beyond the breaking strain of the elastic tissue, and consequent loss of contractility of the affected parts of the lungs. Emphysema arises from two kinds of mechanical causes; one by pressure from within the lung, as by coughing or speaking, or flute or trombone playing; another by expansion of the chest during dyspnœa, as in asthmatic spasm of the lung. I have no record of the actual amount of pressure at which the lung yields, but it is not much above forty-five inches of water in a perpendicular column. The yielding is gradual, and when it has once taken place requires a long rest for a spontaneous cure. Coughing is the commonest cause, and nearly all persons who are affected with catarrh, bronchitis, or spasmodic neuralgic cough, acquire some emphysema at the lower edge of the lung. Emphysema by suction is no less common; it occurs in asthmatic persons as an aggravation to every severe attack.

From this fact arises the great practical rule to symptomatically subdue coughing by sedatives, and conciliate the bronchial tubes by expectorants, notably ammonium chloride. The latter salt has the advantage of liquefying the adhesive ropy mucus which causes most distress in periodic asthma. This result is merely a chemical one, the ordinary effect of the chloride upon the mucine; it therefore requires some time as well as some quantity; doses of ten to fifteen

grains in twenty-four hours mostly do all they are theoretically able to do.

The lungs should be protected from excessive coughing in *young* people particularly. Many children die nominally from *whooping cough*—really from emphysema and circumscribed pneumonia. Pertussis, therefore, should never be left untreated: while we know that there is no direct medication of the disease, there is great power in symptomatic treatment, employing sedatives and expectorants. Even volatile anæsthetics, such as chloroform, are sometimes required, often useful. The late Dr. Varrentrapp's treatment of pneumonia by chloroform was parallel to this. He symptomatically eased the pain, permitted deeper inspiration, and thereby expectoration, so that the risky emetic treatment often became unnecessary.

Most players of wind instruments are liable to, or actually suffer from, emphysema. Virtuosi on the flute are the greatest sufferers. The illness makes its inroad when the great effort has to be made during catarrhal indisposition. This is also the case with singers, actors, preachers, and, most prominently, with political public speakers, who endeavour to reach the ears of large audiences. I have known a number of such permanently maimed by excessive efforts. This danger is not sufficiently known, and requires careful medical attention and treatment.

Cough from laryngeal irritation is a most powerful cause of emphysema of the lungs, and of abdominal trouble, enlarged liver, and frequently of inguinal hernia. A medical colleague was treated for aphonia by probings and caustics by a renowned specialist, and coughed during more than six hours after every application; he would not take morphia, though he was a professor of therapeutics. He contracted inguinal hernia on each side, and had to be trussed in bed and out of it to his death. I might relate several such cases from my own experience. Some of them were, however, not due to emphysema, but bronchectasis, which, rare in the young, is more common in adults of hard fibre. One such case I observed in a gentleman aged 30. Here the mucus from the ectasis, a bronchial cavity, could be expelled only by the patient inclining his body head downwards; without this position the coughing lasted for hours.

Concurrent bronchectasis and emphysema are difficult to diagnose.

Extreme emphysema in young persons between 18 and 36 years is a most painful disease, particularly when the thorax becomes barrel-shaped early in life. If such cases do not bear morphia, even when aided by atropia, one stands help-

less before extreme suffering. So-called climatic places, sea voyages, alpine snow dominions, all have I seen to fail under such conditions; a patient, however, did well in tropical Australia, and I saw in the newspaper a short time ago that he had become a father. Concurrence of emphysema with pulmonary tubercle is not very frequent, or at least not of high degree. This was formerly noted, and it was supposed that they were antagonistic, like cancer and tubercle.

The phenomena presented by the genesis and existence of emphysema teach that all severe coughing from irritation not accompanied by much bronchorrhœa must be subdued; cough from laryngeal irritation, or neuralgia of the pneumogastric or its recurrent branch more particularly; the recurrent branch has to be closely watched in children, as it is liable to be irritated by swelled lymphatic glands in the bifurcation of the trachea, independently of, but also in connection with, pertussis. I have never yet known a case of asthma in which there was not some emphysema; I distinguish the cases in which established emphysema causes a fit of asthma by periodical accumulations of mucus in the expanded emphysematic parts. In all these cases opium preparations were relied upon, and had an unquestionable sedative and expectorant effect.

In many cases the asthmatic fit is followed by some albumen in the urine. In some cases of chronic asthma from specific or unknown, mainly inherited, causes, albuminuria supervenes. Such is sometimes not accompanied with casts of the tubules, while albumen rises to 7 per 1,000, and varies between 2 and 5, sinking to 0·5 occasionally. Sometimes there are dropsical symptoms, but I have always combated them successfully by the hot air sweating bath, applied to the patient in his bed. In such treatment, with the aid of morphia and ammon. chloride, the heart must be carefully watched; when it is weak or very fast, only low temperature, not exceeding 120° F., are admissible. But most emphysematous patients are greatly benefited by the hot air bath, in whatever form it may be applied.

In a number of cases of *emphysema* of the lungs I have found the copious sputa to contain *albumen*. I have not found any special indication to arise from that concurrence, but it makes the prognosis doubtful, and exhibits a special change in the serum-albumen, in the blood itself, which seems to predispose the patient to the appearance of albumen by the kidneys. Such cases are liable to phlegmonic attacks, which apparently are independent of the emphysema. But they are really caused by an accumulation in the blood of uncrystallisable lower albuminoids, so-called entractives, which

also obstruct and enlarge both liver and spleen. The bile then also contains albumen.

Dropsical symptoms occur in emphysema of extreme degree, but in absence of typical kidney diseases yield to treatment.

We should therefore *prevent emphysema* from being contracted or from becoming chronic when it has appeared; we should treat it *energetically* on the principle stated to limit it, subdue its effects by sedatives and expectorants energetically applied.

In the sedative treatment of such cases of emphysema, called asthma, one has to guard against the use of excess of opiates, while securing a sufficiency to effect the purpose. One of my patients had to take ten grains of hydrochlorate of morphia in twenty-four hours; albuminuria makes subcutaneous application impossible, as the punctures are liable to inflame or even suppurate. In attacks going to the height of asphyxia at the wrist, chloroform, or better, A.E.C. mixture, has to be applied, with great relief. In such a case the tympanic lungs filled to the lower half of the chest, and it was a marvel, even to the physician, that the patient lived, being only 36 years of age, and having exhausted many climatic and other proposed cures.

In some cases I have applied the smoke of puffball, lycoperdon giganteum, for the relief of emphysematic asthma; it may be applied just before the attack threatens; in cases in which opiates cause sickness it produces a feeling of the same. But like the opium-smoke it is too feeble a remedy in chronic cases. Pharmacy should supply a concentrated preparation of its highly active ingredient.

Dr. CAMPBELL POPE: With regard to fixation of the chest-walls I should like to point out another cause. We have doubtless all of us noted how frequently our patients with chronic bronchitis and emphysema are big muscular men with large chest girth and capacity. Such men frequently use very shallow breathing, as their capacity being so great there is not the same need for full exercise of the expansive muscles of respiration. They can aërate their blood with little chest movement; this predisposes to fixation of the rib joints and ossification of cartilages. Furthermore, such shallow respiration often leads to bodily inactivity; deposition of abdomina fat occurs, and the great weight of the abdomen, by dragging on the ribs, still further accentuates the fixation. Thus is produced a large chest with little mobility, and when the patient catches cold and coughs the less supported parts, viz., the apices and lung margins, rapidly become emphysematous. The patient has then no lung mobility to speak of, the unsupported portions of his lungs are emphysematous,

and the sound portions are compressed by the rigid thorax. The well-known symptoms then follow. The breathlessness caused by the weight of the abdomen may be very greatly relieved by an abdominal belt so constructed as to exercise a lifting force.

Dr. HARRY CAMPBELL: I am not inclined to attach the same importance as Dr. Thudichum to the blowing of wind instruments as a cause of emphysema, seeing that cornet players, who employ a very strong blast of air in playing, appear to retain the power of sustaining a long note even when well advanced in age. This is a point well worthy of investigation. Nor do I think with Dr. Thudichum and most authorities that the cough of bronchitis is the chief factor in inducing the emphysema which is so apt to accompany the chronic form of this disease. The dyspnœa associated with bronchitis is, I believe, an even more important factor, causing, as it does, hyper-expansion of the lungs, and thus a permanent overstretching of the alveoli. Dr. Campbell Pope's view, that large-lunged people are apt to get fixed chests because they are not under the same necessity as ordinary people to take deep breaths, is ingenious. Whatever truth there may be in it, it is certain that habitually shallow breathing induces fixity of the chest, and it is for this reason that the thorax is apt to get fixed in people leading sedentary lives. With regard to Dr. Pope's remarks as to the part played by obesity in causing emphysema, I would point out that the chest is expanded in typical instances of this disease, while his theory requires that it should be contracted.

Ordinary Meeting—May 7, 1897.

W. BRUCE CLARKE, M.B., F.R.C.S., President, in the Chair.

Specimen of Carcinomatous Stricture of the Ascending Colon.

Mr. MCADAM ECCLES: This specimen is from a man aged 44, who had symptoms of chronic obstruction for about six months, followed by acute symptoms which supervened on May 1 last, for which median laparotomy was performed six days later. The sigmoid was found empty, the cæcum distended, and a hard mass in the ascending colon. A lateral incision was made and the growth drawn out and excised. The ileum was fixed in the wound.

Mr. BIDWELL then read a paper on "The Value and Safety of Abdominal Exploration in Obscure Cases," which is published on page 165. The following discussion took place:—

Mr. ALBAN DORAN: I have found Langenbach's incision very useful for exploring doubtful swellings in the region of the liver. It allows the operator to explore both kidneys,

which is always advisable, as I know of a case where both were found diseased, so that the operator refrained from removing a tumour apparently omental. I may also relate a case precisely similar to No. 7 in the Liver Series. I found a movable kidney under the omentum close to the gall-bladder. As was done in No. 7, I fixed the kidney, with good results. I believe that these exploratory incisions are, in themselves, of little danger. I once lost a case of cirrhosis of the liver and ascites, where I made an incision suspecting that an ovarian cyst existed as well; but the liver and kidneys were extensively diseased. As to peritonitis, the chronic form is often cured by the incision. I should like to ask Mr. Bidwell what he thinks of incision for tuberculous peritonitis; I myself have had very good results. Again, does Mr. Bidwell prefer a single set of deep interrupted sutures? One great advantage of this kind of suture is that the wounded structures are not handled so much as when the layers are sutured separately. The median incision does well in that manner, except in a fat subject where the sheath of the recti require a continuous suture, and in a very thin case where the same is needed lest the peritoneum be everted so as to hinder union. Does Mr. Bidwell unite the muscular layer separately in a Langenbach's incision?

Mr. McAdam Eccles: When dealing with an abdominal case which is so obscure that the question of an exploratory laparotomy arises, one is bound to put before the patient or his friends the points for and against the operation. In the majority of cases the advantages which accrue from the exploration far outweigh the disadvantages; still these latter must be faced. Mr. Bidwell has quite rightly said that septic peritonitis ought not to, and does but rarely, occur; but one must remember that, as Mr. Doran has remarked, ventral herniæ do result, and I would also draw attention to the fact that there are an increasing number of cases in which subsequent adhesion of the intestines ensues. These may lead to intestinal obstruction. Exploratory incisions may reveal tuberculous peritonitis, but it may at the same time bring about its cure. This class of cases in so many instances progresses unfavourably, if merely treated medically, that I am sure it is well to make an abdominal incision in most of them, in order to establish the diagnosis and help towards recovery. Another series of cases are those of retro-peritoneal abscesses, in which symptoms of pressure on the intestines, &c., occur. These often need an exploratory incision for diagnosis, and with care the pus may then be evacuated across the peritoneal cavity.

Dr. Herbert Snow: I desire to call attention to a practical matter apparent in two of Mr. Bidwell's cases, and

possibly overlooked in others through too rapid discharge from hospital, viz., the benefit conferred by laparotomy pure and simple on ineradicable malignant disease of the intestinal tract or parietes. In tuberculosis, the peritoneum recovers its tone, and the patient is cured even when much of the tuberculous deposit must have been left behind. In a minor degree the same thing takes place in cancer, the symptoms being not merely relieved, but the advance of the growth arrested, sometimes very materially. My own experience is hardly as yet sufficient to warrant me in laying down a rule that the abdomen should be opened as a routine measure of treatment, independently of any further operative procedure; but the marked amelioration I have witnessed in a limited number of instances goes far to suggest this; and I think the point well worthy of attention in all future laparotomies performed under such circumstances.

Mr. KEETLEY: One is struck by the fact that, of all the tumours found in Mr. Bidwell's explorations, not one was removable. Though it is true that some tumours disappear spontaneously after a laparotomy, so happy an event is not frequent. The question then arises—cannot a diagnosis be made earlier? The answer does not lie altogether in wholesale exploratory laparotomy. That would lead to quite different results from those of Mr. Bidwell's judicious operations. Many operations would be quite fruitless, and it is precisely in the cases where nothing was to be found that the viscera would be most disturbed and handled in trying to find something. I quite agree that peritonitis ought never to follow an ordinary abdominal section, but I have seen hypochondriacal persons extremely ill, without peritonitis, after mere abdominal exploration. There are also other obvious objections to thinking as lightly of a laparotomy as of a laryngoscopic examination. As a matter of fact, the symptoms of the *first* stage of chronic abdominal obstructions and the like have never been thoroughly studied. Until recently, surgery offered nothing to such sufferers. Things are now different, and I would ask general practitioners and physicians to study earnestly the diagnosis of the early stages of the complaints in question. The symptoms now given in books are mostly those of a stage too advanced for any surgery except palliative.

Mr. L. A. BIDWELL: I had not referred to laparotomy in tuberculous peritonitis since the only case in which I have operated was that of an acute case. In reply to Mr. Doran's inquiry as to the method employed in closing the abdominal wound, since this series of cases extends over six years, I have used many methods, but now generally unite the peritoneum with a continuous silk suture, and then close the other layers

and skin with a single row of silkworm gut sutures. In reply to the question about Loretta's operation, a definite swelling about the size of a walnut could be felt at the pylorus. When the stomach was opened, considerable difficulty was experienced in getting the little finger through the pylorus; after this the index finger was passed, then the index and little fingers, and finally two index fingers, when the pylorus was dilated with about the same force required to dilate the sphincter ani. In answer to Dr. Snow's remarks about the benefit derived in malignant cases from simple exploration, I was much impressed with the striking benefit which the two cases experienced, and the long period (in one case over six months) during which the benefit was maintained.

The Principle of Anticipatory Gland-Excison in Cancer Surgery.

Dr. HERBERT SNOW read a paper with the above title which is published on page 182.

The following discussion then ensued:—

Mr. L. A. BIDWELL: I should like to ask Dr. Snow whether the glands removed were examined microscopically, and so were proved to be already infected; if so, I should scarcely consider their removal as anticipatory, but rather as a part of a complete operation. All surgeons now recognise the importance of clearing out the axilla in mammary carcinoma, even though no evidence of enlarged glands can be obtained. Others, myself included, consider that it is also necessary to remove the lymph channels running from the breast to the glands, and so make it a rule to remove the breast and glands in one piece. Does Dr. Snow agree with the necessity of removing the lymphatic channels as well as the glands? If so, I suppose that he would advise either the division of the lower jaw or Kocher's operation in every case of removal of the tongue.

Dr. SNOW: I have here the microscopical section of a lymph-gland, normal in size, but full of *globes epidermiques*. The presence of malignancy has been microscopically proved in all my cases since 1886. I have only known of one supposed case of tongue epithelioma which did not promptly recur without concurrent gland-removal, and in that instance, now some twenty years ago, I was led to the conclusion that an erroneous diagnosis had been made. The lymph-currents are rapid, and cell-particles are arrested only in the glands. Hence I pay no attention whatever to removal of the lymphatic vessels as such, though I am careful always to excise a wide area of subcutaneous or other dangerous tissue around the palpable carcinoma.

CLINICAL EVENING.

W. BRUCE CLARKE, M.B, F.R.C.S., President, in the Chair.

June 4, 1897.

A Case of Epilepsy.

Dr. SUTHERLAND: This patient, whose age is 32, when five months pregnant gave birth to a dead child, which was delivered by Mr. De Castro, R.M.O. to the St. George's Dispensary. After this she had three attacks of grand mal, and two of petit mal. The treatment consisted of bromide of potassium and arsenic. No further fits occurred. The peculiarity of the case is that the epileptic attacks were confined to a period of only over three weeks. Again, it is remarkable that a person of her age should make so complete and rapid a recovery.

Congenital Absence of the Iris.

Dr. SUTHERLAND: I have here the daughter of the previous patient, in whom there is congenital absence of the iris. Her age is 9. The same defect is present in her father and brother. Her father, mother and brother have been epileptic, and so was this child when teething. Her general health is good.

Partial Greyness of the Hair.

Dr. SUTHERLAND: This patient is 12 years old; the partial greyness of her hair now present is hereditary, her father having become grey at 17, and also an uncle and aunt at the same age. The loss of colour is attributed to shock from her having been frightened by a parrot. Her general health is good.

Dr. SEYMOUR TAYLOR: It would be interesting to know if the first patient shown has any symptoms of dreamy state, since the hyperphysiological discharge of the cortical cells, although mostly limited to, or most severe in the Rolandic area, may also be limited to the psychical area of the frontal lobes, thus giving rise not to motor convulsions, but to wonderful thoughts, or visions, the condition being known as dreamy state.

Dr. DE CASTRO: The following are the facts about the epileptic attacks in the first case. The first fit took place during the morning while she was attending to house-work. There was no aura beyond loss of vision; she was able to sit down, but she subsequently fell and cut her forehead against the fireplace. About an hour and a half later, upon entire recovery, a distinct epileptic attack occurred while she was lying down, the face and limbs being con-

vulsed, but the patient does not remember any previous symptoms. The second fit led to the conclusion that the earlier one was also epileptiform.

Rodent Ulcer of the Axilla.

Mr. McAdam Eccles: This patient, aged 75, first noticed five years ago that he had a small raised patch in the left axilla similar to those now to be seen on other parts of his trunk. This irritated him and he scratched it and made it bleed. Ever since it has slowly ulcerated. The characters of the ulcer are typical of a "rodent ulcer"—extensive superficial ulceration with "rolled" edges, sero-sanious discharge, and but little induration. No enlarged lymphatic glands can be detected. The patient has not lost flesh, and is but little inconvenienced by the growth. Microscopic section indicates the usual appearance of rodent ulcer. He has had no operative treatment. Rodent ulcer away from the face is extremely rare. Out of 66 cases collected by Mr. Anthony Bowlby (Pathological Society's *Trans.*, 1894, vol. xxiv.) only two were on other parts of the body than the head and face. Such a growth occasionally occurs in the corresponding position, namely, the groin.

Symmetrical Nodules of a Fibrous Nature on the Posterior Aspect of the Ulnæ, in a Woman the subject of Rheumatoid Arthritis.

Mr. McAdam Eccles: The patient, aged 48, has been an umbrella and parasol maker. There is no history of syphilis, of rheumatic fever, or gout. For *five years* she has had pain in the small joints of the fingers and toes. About a year ago she first noticed swellings at the back of both elbows, the right always being the most painful and the larger. Later, two smaller swellings appeared, a little further forward, of a like nature. There is also marked evidence of rheumatoid disease of the synovial sheaths of the tendons about the wrist, and rheumatoid arthritis of the inter-phalangeal joints with typical ulnar deflection of the right fingers. The pain in these joints is always worse in wet weather.

Mr. Rickard Lloyd: I think it would be interesting to watch the effect of celandine on the rodent ulcer if, for any reason, Mr. Eccles did not remove it freely, as some reports have shown that this drug has had palliative effects in cases of cancer.

Land Scurvy due to Privation.

Dr. H. P. Potter: This patient, aged 59, is suffering from scurvy. There has been an entire absence from his diet of vegetables for some considerable time. He now has extravasations of blood on the dorsum of each foot, in the calf of one

leg, ecchymoses and purpura of the legs and arms, spongy and bleeding gums, and marked fœtor of the breath. Under a liberal diet, including potatoes, he is recovering.

Mr. McAdam Eccles: I should like to ask if hæmorrhages into the body cavities have been observed in this case.

Dr. Gould May: I consider the case to be one of purpura hæmorrhagica.

Dr. Clippingdale: It would be interesting to know if retinal hæmorrhages are present.

Dr. H. P. Potter: There are no symptoms pointing to internal hæmorrhages.

Cyst of Thyroid Duct.

Mr. Bidwell: This patient, aged 17, first noticed a swelling just above the hyoid bone ten months ago; it was quite small, but has gradually increased to the size of a hazel nut. At times there is some pain. The tumour is very hard, and has an indistinct feeling of fluctuation; it moves with deglutition, but is not freely movable on the deeper tissues. There are no enlarged glands in the neck.

Primary Chancre.

Mr. Bidwell: Three months ago this patient, aged 34, was scratched by another man. The wound healed, but a month later he noticed a pimple, and thinks that this was poisoned. The sore gradually got larger. There is now a raised patch the size of a shilling in the centre of the right cheek, only slightly tender; the surface is devoid of granulations, and is glazed. The glands beneath the jaw are enlarged. The throat is slightly congested; there is no eruption upon the abdomen. He has never had any venereal disease.

Tuberculous Tumour.

Mr. Bidwell: Three months ago this patient, whose age is 51, noticed a swelling of the left wrist, and a few days later also a swelling just below and to the outer side of the right elbow joint. The swelling over the left wrist is evidently in connection with the anterior tendon sheath; that near the right elbow is apparently subcutaneous. On exploring the tumour with a needle thin pus was obtained. This has not been bacteriologically examined, but it resembled the pus from tuberculous abscesses. There is no history of syphilis, but the patient has been treated with iodide of potash in large doses, without, however, producing any effect on the tumour.

Dr. Potter: A noteworthy point about the case of chancre is the absence of any secondary symptoms.

Dr. Bennett: I should like to know something as to the supposed source of the infection.

Cases of Leucodermia.

Dr. A. N. BURRELL: This patient, aged 50, in April, 1896, noticed a brown patch in the centre of the forehead. A white patch appeared in the centre of this. This spread irregularly. Brown pigment spread over most of face and into the scalp. White patches are now present on the cheek and in front of the ear. In April of this year he was in the Kensington Infirmary, where counter-irritants were employed over some large patches of the pigmentation. The second case is a man aged 20, with extensive pigmentation of face. Irregular white areas. The disease first appeared at the left corner of the mouth. Now his moustache in that place is white. The disease is of four months' duration.

Fracture of the Base of the Skull.

Dr. SEYMOUR TAYLOR: In this man, aged 50, an injury to the head was received twelve weeks ago. He was admitted to a hospital in a comatose condition, and with hæmorrhage from his right ear. He was one month in the hospital and was then discharged apparently cured, but with weakness of the right side of his face. Further examination showed that he had Bell's palsy, with drummings in the right ear, partial loss of taste on the right side of the tongue, paresis of the right side of the soft palate. No deafness. The diagnosis is fracture into the petrous portion of the temporal bone, or hæmorrhage into the aqueduct of Fallopius.

HOLOCAINE, A NEW ANÆSTHETIC.—Gutmann (*Deutsche Med. Wochen.*, March 11, 1897) describes the advantages and disadvantages of a new local anæsthetic, holocaine, which is soluble to the extent of 2·5 per cent. A solution of the hydrochlorate of a strength of 1 per cent. is bitter, of neutral reaction, and is unchanged by boiling. Three or four drops of this solution produced anæsthesia in the eye of a rabbit in from one-half to two minutes, which lasted about ten minutes. Its action in the human eye is similar. Its advantages over cocaine are that it more quickly produces anæsthesia, and that while dilatation of the pupil often continues for twenty-four hours after the use of cocaine, holocaine has no such action. Unfortunately the subcutaneous injection of this drug is dangerous; and another disadvantage in connection with its use is the fact that it can only be sterilised in glass which does not contain alkali, otherwise numerous fine crystals are precipitated.

The Mirror of Practice.

TWO CASES OF PRIMARY SARCOMA OF THE KIDNEY.

By Charles W. Chapman, M.D., M.R.C.P.

Physician to the National Hospital for Diseases of the Heart; late Physician to the Farringdon Dispensary.

The first case came under my observation during 1892, when I had charge of Dr. Evershed's patients at the North London Consumption Hospital. To Dr. Evershed my thanks are due for permission to publish the case, and to Dr. Smale, the House Physician, for his assistance in preparing these notes.

G. S., aged 50, labourer, became an in-patient on July 28, 1892.

History.—At 23 years of age he entered the Metropolitan Police Force. Seven years ago he strained his right loin in jumping over the parapet of a bridge to save a child who was drowning in the Regent's Canal. He has had a winter cough for the last six years. In January, 1892, he had influenza, and soon after he noticed a lump in his right loin, but as he had no pain he did not take special notice of it. Later on the cough became severe, and on one occasion there was hæmoptysis; he has been losing flesh rapidly. Father and mother alive and well, aged 73 and 74 respectively; one brother died at 23 of phthisis. On admission he was much emaciated, and had hectic flush on the cheeks.

Physical Examination.—Chest.—At both apices there was tubular breathing, at right apex faint whispered pectoriloquy, a few faint crackling *râles*. Abdomen.—Stomach dilated. In right flank a dull area extending nearly to the middle line; a resonant area divided it from the liver and the dulness stopped at the brim of the pelvis. An elastic swelling could be felt but no fluctuation could be made out. Urine acid, sp. gr. 1026, albumin $\frac{3}{5}$, no blood or sugar; microscopically no definite cells seen, only granular *débris*. Weight 8 st. $2\frac{1}{2}$ lbs.; height 6 ft. $1\frac{1}{2}$ in. Ankles swollen.

August 3.—Œdema extended to upper part of thighs. An obscure elastic thrill over swelling; over front of swelling a band of resonance could be mapped out passing parallel to axis of body. Tumour diagnosed as renal.

August 7.—Band of resonance absent. A hypodermic needle passed into tumour from the lateral aspect appeared to enter a soft elastic mass; no fluid obtained.

August 10.—Severe hæmaturia; no pus cells could be

detected; patient very weak; vomiting and nausea; some incontinence of urine, pain in right flank, tympanitis and hiccough; temperature 95°.

August 12.—Consultation with Mr. T. Smith. Tumour again aspirated and a small amount of puriform fluid withdrawn. Under microscope fluid contained chiefly granular *débris*. No crystals. Patient rapidly emaciated, and on August 16 he passed *per urethram* three pints of blood-stained fluid. On the 18th nearly the same quantity of fluid was passed, and on the 20th he died.

Post-mortem.—Lungs.—Old adhesions at apices, with radiating cicatrices on section; lower lobes congested. Heart.—Some puckering of mitral valve, early atheroma in aorta. Abdomen.—No signs of recent peritonitis. Whole of iliac and lumbar regions occupied by large, semi-elastic, rounded tumour; cæcum and colon lay directly in front and tumour overlapped the vena cava and was adherent to the bowel in front. Stomach dilated, otherwise it and the other viscera were normal. Spleen contained a small cyst. The right spermatic artery and vein crossed the tumour; the right ureter could be traced alongside of tumour to its upper part, where some apparently healthy kidney remained. Left kidney enlarged and fairly normal. On section the tumour was found to consist of a growth involving lower half of the kidney enclosed in renal capsule; the growth was soft and white, and its centre had broken down, upper part fairly normal. Microscopic examination showed spindle cells in a loose stroma.

With this case may be contrasted one seen in private for the most part in consultation with Dr. Wood, of Penshurst.

The patient, a gentleman, about 43 years of age, consulted me on September 10, 1895. He then complained of pain in the right loin, radiating in the course of the ureter. He was very fond of hunting, and had had a fall on his right side during the previous season, which, however, caused him only a little temporary inconvenience. Eighteen months before he had passed a stone which proved to be a uric acid one, and he had occasionally passed "gravel" since. He was told that in all probability he was about to pass another stone. Alkalies were prescribed and rest ordered. As is not infrequently the case the patient formed his own opinion of his illness and acted upon it. On the conviction that he was suffering from "liver" he went to Scotland, and, getting a doctor there to agree with him, went through a course of mercurial and saline aperients. On October 14 he returned to town looking extremely worn and ill; the lumbar pain was now associated with occasional hæmaturia. As it seemed probable the kidney

would soon have to be explored the patient decided to go to his country house, where I frequently met Dr. Wood, who had charge of the case. On November 1 we had the advantage of a consultation with Sir William Roberts, who agreed with the calculus theory. The urine was frequently examined, and at times uric acid was found, but no pus or tubercle bacilli; on some occasions uric acid was abundant. The kidney was now enlarging, and an operation was decided upon by Mr. Henry Morris, who saw the patient with us at this time. On November 10 the right kidney was cut down upon. On exposing the organ it was clear that we had to deal with a sarcoma. As the bleeding was severe and the patient very feeble, it was decided not to proceed any further with the operation. The pain was lessened and the hæmaturia diminished by the operation, but the case terminated fatally five weeks afterwards. No *post-mortem* could be obtained.

It is to be noted that in both cases there was a history of injury on the side where the disease was: in each the right kidney was the one affected. Both patients had hæmaturia associated with pain in the region of the kidney. One had a personal history of pulmonary tuberculous disease, the other of present phthisis in his brother. One had passed a uric acid calculus, and during the course of his illness his urine had at times much uric acid deposit. In neither case were tubercle bacilli found.

In the early stage of the first case the presumption was in favour of tuberculous disease, but the continued absence of pus and tubercle bacilli in the urine, the quiescent state of the lung lesions combined with freedom from disease in all the organs excepting the one kidney, made the diagnosis tend more to malignant disease as the case progressed. In the second case everything up to a certain point pointed to a diagnosis of calculus. Both illustrate the difficulties in diagnosis in such cases.

LARVÆ IN THE NASAL PASSAGES.

By Vincent Dickinson, M.D., M.R.C.P.

The following case, being somewhat unusual, is perhaps worth recording, if not for its own sake, at least as furnishing a fitting text for a warning against a practice which might cause a repetition of the disagreeable experience in others.

A lady recently consulted me and gave me this history: that she had for three days suffered from severe neuralgic pain in the frontal sinus, supraorbital and parietal regions, on the right side of the head, as far back as the occiput. The previous night it had kept her awake all night, and in the

morning, on blowing her nose, to her intense alarm a maggot was discharged alive, which she kept for my inspection. Examination revealed nothing abnormal about the nasal passages; there was, perhaps, slight excess of secretion on the right side, and the neuralgic pain had steadily diminished since the animal's expulsion. An inhalation of thymol and carbolic vapour was prescribed, and all that was further necessary was to allay the patient's alarm. There were no subsequent symptoms of any kind. The maggot resembled the larva of the common house-fly or a closely allied species; however, it could not be identified in a larval form of this type. It was kept alive some time in the hope of its pupating, but, unfortunately, it died before this happened.

The only explanation of the occurrence seems to be that the patient, who is very fond of flowers, was in the habit of burying her nose in them and taking long and forcible inspirations; and during the enjoyment of this act—which she remembers distinctly perpetrating on a large bunch of Neapolitan violets—she must have inhaled the ovum, which became lodged in a fold of mucous membrane and subsequently hatched; the pain was obviously caused by the movement of the larva on the surface of the delicate pituitary membrane.

It seems that larvæ can remain for some time in the nasal passages, and even pass through the chrysalis stage, and develop there into the perfect insect. Dr. Jacobsen, of Havana (*Brit. Med. Journ.*, 1889, vol. ii., p. 1238), records the case of a man aged 27, who had suffered from nasal discharge, itching and burning for two months. On several occasions he had noticed when blowing his nose that the mucus contained maggots, and on one occasion a small blue fly came out of his nose. The result may be very disastrous, for in Dr. Jacobsen's case the mucous membrane lining the nasal fossæ was uniformly congested and ulcerated in parts, and the arch of the palate was perforated.

In a case of Dr. Menocal's (*Revista de Ciencias Medicas*, 1889) death occurred in four days from acute encephalitis, the result of perforation of the cribriform plate of the ethmoid, causing meningitis of the base, and a large cerebral abscess occupying almost the whole of the anterior lobes. Coquerel also relates a fatal case (*Archives generales*, May, 1858) where the nasal bones were gangrenous; ten larvæ were found crawling on the pituitary membrane, and there was meningitis and encephalitis.

In a case reported by Dr. Jennings (*Med. Press and Circular*, 1890, vol. ii., p. 263) the termination was more satisfactory, for although there had been considerable headache, inflam-

mation and offensive discharge before the first worm was coughed up, yet after spraying some chloroform up the nostrils fifty-seven worms were expelled, and in a few days the patient was perfectly well.

In Cuba the *lucilia hominivorax* or *hominivora*, a common species of fly, seems to have a predilection for the nostrils of anyone lying asleep in the open air, and the presence of ozæna is a powerful attraction to it. The fly is ·35 inches long, palpæ yellow, head and mandibles fallow colour covered with golden yellow down, head very large, broader at its base than at its thoracic end. Thorax deep blue with a purplish sheen, with bands of black and faint yellow. Abdomen same colour as thorax, feet black, wings transparent, slightly opaque with black veins. Coquerel regards the presence of the insect as accidental and not parasitic in nature. In Dr. Jennings' case mentioned above, the *screw worm*, the larvæ of the blow fly, was the species observed.

Worms in the nose, or *Penash*, is a common malady in some parts of India, owing to the natives apathetically allowing flies to cluster round the eyes and nose. Usually there is antecedent syphilitic or tuberculous ulceration of the nasal mucous membrane; the larvæ are those of the common fly, which, with its well-known pertinacity, attack any exposed parts. Some cases prove fatal from meningitis, others from debility and exhaustion, though probably the original tuberculosis or syphilis is responsible for this. Laboulblene reported fifteen cases, of which nine ended fatally (*Lond. Med. Record*, 1885, p. 212). On the other hand, Mr. Lahory, a native surgeon at Allyghur (*Indian Annual Med. Sci.*, 1855, p. 96), says he has never observed symptoms indicative of inflammation of the brain, and Dr. Lyons (*Ibid.*, No. 15, p. 55) says it rarely proves fatal, although the subjects of it were ill-fed and tuberculous. It seldom occurs among the better class of natives, and never among the Europeans. Camels suffer in the same way; the ring or piece of wood to which the drawing string is attached excites inflammation, and flies deposit their ova in the discharge.

Treatment may be directed to destroying the intruders, and for this purpose 1 per cent. solution of carbolic may be used as an irrigator or irrigations of benzine. In the West Indies, where larvæ in the nose and ear are frequent, calomel insufflation is considered a specific, and in Mexico pure chloroform is used as an injection. English medical men in the West Indies use local injections of tobacco infused in turpentine. But Inspector-General Lawrie relies on snuff, tobacco being a virulent poison to insects. Camphor, solution of alum, and in severe cases perchloride of mercury,

1 to 600, may be used. Powdered veratria has been tried. Dr. Roura washes out the nostril with 1 in 20 carbolic, and then insufflates calomel (*Rev. de Medicine y Cirugia Practicas*, November 22, 1884). Black wash has been efficacious in the hands of practitioners in Rajputana. Coquerel, while laying stress on the importance of injections, admits the difficulty of removing the animals after inflammation of the mucous membrane has set in. Trephining the frontal sinus would appear to be a proper proceeding in intractable and severe cases, but as far as I can gather it has not been tried. I append here a short bibliography upon the subject.

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A CASE OF LINGUAL VARIX WITH SEVERE PAROXYSMAL DYSPNŒA.

BY MAYO COLLIER, M.S., F.R.C.S.

Surgeon to the North-West London Hospital.

THAT many abnormal sensations and functional disorders in and about the pharynx and larynx may be, and often are, associated with and attributed to some enlargement of the veins at the root of the tongue, is common knowledge. The causal relationship of one to the other has yet to be established in most cases. This can only be done by the careful examination of a large number of normal individuals—in the first place individuals not complaining of any subjective symptoms in or about the pharynx. Many of these have well-marked lingual varices. So far a marked lingual varix may exist for many years or all time without setting up abnormal symptoms. Secondly, a lingual varix may set up abnormal sensations and functional disorders in and around the pharynx and larynx. The following case is a typical example of the causal association of lingual varix and functional disorders of the pharynx and larynx.

Mrs. D., aged 34, married, and the niece of a well-known medical friend, had complained for the last twelve months of attacks of severe paroxysmal dyspnœa, simulating that form associated with aortic aneurism. There was some abnormal

protrusion of both eyeballs and a general enlargement of the thyroid gland, dating some years back and following the exhaustive operations of closely and continuously nursing a sick friend.

The lungs, heart, liver and kidneys were apparently in a healthy state. There was no history of any severe affections of the throat or other parts that could have in any way set up or encouraged the present state of things. The attacks of dyspnœa commenced with a feeling of fulness or choking and constriction of the neck.

The dyspnœa was so severe as to incapacitate the patient entirely. The attacks lasted from twenty minutes to an hour, sometimes recurring with intervals of rest limited to five or ten minutes. The attacks never occurred during sleep or in the recumbent position.

A marked feature of the case was the association of copious perspirations at all times. Loss of flesh was also a prominent symptom.

The case having been in the hands of the general physician, and many opinions and consultations obtained without benefit, my friend requested me to examine the larynx and pharynx and nose, in order to put out of court if possible positive evidence of disease in these parts. The larynx was apparently quite normal, as also the nose and pharynx. At the root of the tongue there was a large lingual tonsil, so large as to fill up and overtop the glosso-epiglottidean pouch and partially bury the apex of the epiglottis. Many and large veins traversed the mass in a direction from before backwards. Being sceptical and shy of attributing this lady's troubles to a state of things that many even denied the possible existence of, I called to our aid Dr. (now Sir) Douglas Powell. He reported the chest as quite free from disease, and on my pointing out the state of things at the root of the tongue readily concurred in the possibility of this being the cause of the whole trouble. The lingual varix and a great part of the lingual tonsil was destroyed in four sittings with the galvano-cautery. Improvement was apparent after the first operation. Each subsequent operation increased the intervals and lessened the severity of the attacks, until their final disappearance after the fourth operation. The speedy and complete, and moreover permanent, disappearance of these attacks of dyspnœa is the best evidence of the interdependence of dyspnœa with lingual varix.

Reviews and Notices of Books.

COUTTS ON INFANTILE SYPHILIS.[1]

In this short volume, which represents the Hunterian Lectures of 1896, Dr. Coutts treats of some of the wider principles involved in infantile syphilis. No attempt has been made to describe fully the course and pathology of the two forms of infantile syphilis, namely, congenital and acquired. Recognising the impossibility of doing so satisfactorily in a short volume of this kind, the author expressly states that he has preferred to deal with some points, especially the more controversial ones, fully, and to leave other and more generally admitted features entirely out of consideration.

In this scheme we find much to praise, as it makes the book eminently readable, and has much value in calling especial attention to points of importance which have been overlooked, either owing to their being compressed into a few words by the mass of detail in the description of the whole disease, or from an ignorance of their importance to the clinician. We hope the book will be as widely read as it deserves, and it is certain that every one will find, on perusing its few pages, that there are still many debateable points in the disease, the investigation of which will not be beyond the reach of even the busiest practitioner, provided he has some, even the slightest, material at hand.

BARRETT ON DENTAL SURGERY.[2]

To compile a simple and elementary book upon an art which possesses an extensive literature, and which has developed in its progress complex methods, must at all times be difficult. It might be easy to make a carping criticism of such a book, to point out that too much has been written under one and too little under another heading, did one not realise the difficulties of presenting in a readable, concise, and withal an accurate manner, the necessary elements of dental surgery for the guidance of the general medical practitioner.

The chapters dealing with irregularities and caries deserve praise, not only for the general accuracy of the information

[1] "Some Aspects of Infantile Syphilis," by J. A. Coutts, M.B.Cantab., M.R.C.P. London: Rivington, Percival & Co., 1897.

[2] "Dental Surgery for General Practitioners and Students of Medicine," by Ashley W. Barrett, M.B.Lond., M.R.C.S., L.D.S., Dental Surgeon to the London Hospital. Third edition. London: H. K. Lewis, 1897.

they contain, but also for the breadth of view taken upon the questions. As it is impossible, however, for the medical practitioner to treat those irregularities which require mechanical means for their correction, it would have been better had less cumbersome plates and other methods less clumsy and more accurate in their action taken the place of the present illustrations.

The introduction of a chapter on artificial dentures is to be highly commended, for it is of importance that the medical practitioner should know something of the subject.

We trust that in a future edition the author will re-write the section dealing with bridge work; this we regret to have to describe as positively weak—the only section of the book which in our judgment deserves such a description. The operation of bridging *small* spaces is now thoroughly established as a practical undertaking, while that of bridging very large spaces, such as that illustrated on p. 108, has been absolutely discarded. Such a bridge, therefore, does not merit illustration. On p. 107 the small bridge illustrated does not represent the usual and accepted method of practice. There are but few dentists who, making a constant practice of inserting small bridges, would ever utilise such a structure as that illustrated.

FENWICK ON THE DISORDERS OF DIGESTION IN INFANCY.[1]

In the above monograph we have a laudable attempt to fill up one of the many gaps in professional education under the modern system. The undoubted success of many of our predecessors in the treatment of children's diseases was largely due to their training under experienced family practitioners. In this book, in addition to useful and practical information on the disorders of digestion, we have the results of pathological research, which give not only a scientific explanation of much valuable, though at times empirical, treatment, but is suggestive of further preventive and remedial measures.

From the management of the nursing mother to that of the child in health and disease, the popular fallacy of the routine necessity for stimulants is condemned, while their value in exceptional instances is approved. Diet is fully considered, and when discussing the value of sterilisation, it is shown

[1] "The Disorders of Digestion in Infancy and Childhood," by W. Soltau Fenwick, M.D., B.S., M.R.C.P., Physician to Out-Patients, Evelina Hospital for Sick Children. London: H. K. Lewis, 1897.

that not only bacteria but the changes produced by them are to be borne in mind. "No amount of sterilisation can convert an actively poisonous milk into nutritious food." In these days of predigested foods, valuable as such aids to nutrition are, the author's note of warning is salutary; he says, "infants who are nourished solely upon predigested foods soon lose their natural powers of digestion, and are apt to suffer from anæmia and rickets, and not infrequently present symptoms allied to scurvy."

The evil results, both immediate and remote, of too frequent and over feeding are emphasised.

In the chapter on diarrhœa we do not find notice of a measure which in our hands has proved of value in otherwise hopeless cases, viz., ounce or even half-ounce injections containing cupri sulph., tinc. opii and brandy.

Under the treatment of constipation in hand-fed children we notice drachm-doses of compound powder of liquorice recommended. We think a young practitioner ordering such doses would not commend himself to the mothers of his little patients.

The value of small doses of calomel (gr. $\frac{1}{8}$) from the antiseptic power of the mercurial salts formed in the digestive tract are noticed, and may be taken to heart by those who favour heroic doses of the remedy as a routine treatment for nearly all children's diseases. When discussing the use of germicidal drugs and their therapeutic value, the writer, evidently having in his mind the innumerable preparations of this class now on the market, remarks, "Experimental research has brought to light a large number of drugs which are endowed with powerful antiseptic properties, and it has been hastily assumed that each of these substances has a therapeutic value in *direct* [the italics are ours] proportion to its germicidal powers. This is, however, a mistake. The alimentary canal of a human being is something more than a test tube; it is a vital organ endowed with the power of absorbing, not only the poisonous products of the bacteria, but also most of the substances which are introduced to destroy them."

The schemes of diet and the formulæ of medicines will be found useful if intelligently prescribed and with allowance for individual idiosyncrasies.

Some repetition is unavoidable in a book of this character, but the volume will be found to be a useful addition to the practitioner's library, and we heartily recommend it.

POST-GRADUATE TUITION IN LONDON.

By C. B. Keetley.

During the autumn vacation the regular courses of lectures are suspended. But the practice of each hospital goes on as usual, and clinical assistancies, dresserships, &c., can be obtained.

In the hospitals to which medical schools are attached, the absence of most of the undergraduates leaves a better opportunity for graduates. The wards are usually in the charge of the younger members of the staff, and the seniors—with whose names strangers may possibly be more familiar—take their holidays at this season. However, this is only partially the case, because the vacation lasts three months, and few medical men are so fortunate as to be able to get away for more than a month or six weeks. American visitors will generally find the "Assistant-physicians;" &c., in charge in August, and their seniors in September—a rule with many exceptions.

The College of Surgeons Library closes at 6 p.m. in August, and altogether in September. On Saturdays it closes at 1 p.m. as usual.

The Library of the Royal Medical and Chirurgical Society (20, Hanover Square) is open in July and September, and that of the British Medical Association in July, August and September (at 429, Strand).

In the October number of this journal will be given the arrangements for post-graduate tuition during the months of October, November and December.

[The Library Report for the past Quarter will appear in the October number of the Journal.]

Pleural Effusion.—Baccelli (*Il. Policlinico*) calls attention to a sign which is an aid in the diagnosis of fluids in the pleura. The patient being made to utter the word "trentatre" (Italian 33) in a whisper, if the fluid is very thin, every letter of the word will be heard; but in proportion as the fluid is thicker, the letters are gradually lost, up to final disappearance of all conduction. The first letter to fail is *r*, then *t*, then *n*, and finally the vowel sounds. In order to hear this "Baccelli's phenomenon," direct auscultation should be used in the antero-lateral and inferior regions of the thorax, and without the stethoscope.

LIST OF NEW MEMBERS DURING THE SESSION 1896-1897.

THE following is the list of new Members elected to the Society during the current Session up to the end of June.

BAINES, E. W. P., M.B.Dur., 11, Cranley Place, S.W.
BEINEMANN, A. J., M.B., M.C.Edin., 64, Shepherd's Bush Green, W.
BISHOP, THOMAS HILL, M.B., M.C.Edin., 4, South Parade, Bedford Park, W.
BOOTH, R. L., M.B., M.C.Edin., 12, Gordon Terrace, Munster Road, Fulham, S.W.
BROMET, E., M.B.Cantab., M.R.C.S., L.R.C.P., Hospital for Women, Soho Square, W.C.
BROWNE, ELLIOTT, L.R.C.S. & P.I., L.M., 5, Cavendish Mansions, Langham Street, S.W.
BUENDIA, N., M.D.Columbia, M.R.C.S., Bagota, Columbia.
BUTLAR, C., M.D.Cantab., 2, Princes Square, Bayswater.
BUTLER, CHARLES, M.R.C.S., L.R.C.P., 53, Devonshire Street, Portland Place, W.
COATES, C., M.D.Oxon., 30, Brechin Place, S.W.
COSENS, C. H., M.R.C.S., L.R.C.P., 49, Oxford Terrace, Hyde Park, W.
CUTLER, L., M.R.C.S., L.R.C.P., 8, Gloucester Road, S.W.
DAVIS, H. J., M.B., M.C.Cantab., West London Hospital, W.
DE CASTRO, GEORGE, M.R.C.S., L.R.C.P., 16, Little Grosvenor Street, Berkeley Square, W.
DUNN, J. C., M.B.Ed., Dispensary, Euston Road.
FÉRÉ, E. N., M.D.Toronto, L.R.C.P.Ed., 12, Northampton Square, E.C.
FERGUSSON, C. Gunnis, M.B., M.C.Glas., 62, Holmdale Road, West Hampstead.
FLAVELLE, J. M., M.R.C.S., L.R.C.P., 3D, Hyde Park Mansions, W.
FORD, F. C., M.B.Dur., 47, Ladbroke Square, W.
GALLOWAY, JAS., M.D.Aber., M.R.C.P., 21, Queen Anne Street, W.
GREGORY, E. THOMAS, L.S.A., 168, Fulham Road, S.W.
GRIFFITH, A. L., M.D.St.And., 606, Harrow Road, W.
HALLEY, W., M.R.C.S., L.R.C.P., Park House, Fulham Road, W.
HILLS, W. C. DILLON, M.R.C.S., L.R.C.P., 17, Redcliffe Gardens, S.W.
HOGG, E. STANLEY, L.R.C.S. & P.Ed., 102, Palace Gardens Terrace, Kensington.
INCE, GODFREY, M.R.C.S., L.R.C.P., Kensington Dispensary, W.
KEEP, A. CORRIE, M.D.Edin., 2, Manchester Square, W.
KIRBY, W. E., M.D.Brux., Hilden Sutton Court Road, Chiswick.
KNIGHT, H., M.R.C.S., L.R.C.P., Morholme, Woking.
LANG, E. J., M.R.C.S., L.R.C.P., 38, Old Bond Street, W.
LYLE, F. W., M.B.Ed., 39, The Avenue, Castle Hill, Ealing.
MCDOUGAL, E. D., M.R.C.S., L.R.C.P., 55, Hans Road, S.W.
MACNAMARA, J., M.B., M.C., 73, Milson Road, West Kensington, W.
MILES, W. ERNEST, F.R.C.S., St. Bartholomew's Hospital, E.C.
MORISON, A., M.D.Ed., M.R.C.P., 14, Upper Berkeley Street, W.
MORISON, H. B., M.B.Dur., M.R.C.S., L.R.C.P., 18, Holland Park Avenue, W.
MOSSMAN, E. VERNON, L.S.A., 317, Waterloo Road, Manchester.
NICOLL, T. VERE, L.R.C.P., M.R.C.S., 147, Cromwell Road, S.W.
OAKLEY, H. CALLENDER, L.R.C.S., L.R.C.P.Ed., 30, Sinclair Road, West Kensington, W.
PARDOE, JOHN C., M.B.Aber., M.R.C.S., St. Peter's Hospital, Henrietta Street, W.C.
PHILPS, F. G. M., M.R.C.S., L.R.C.P., 76, Redcliffe Gardens, S.W.

PORTER, R. J., M.R.C.S., L.R.C.P., 61, St. Dunstan's Road, S.W.
POTTER, L. F., M.D.Brux., M.R.C.S., L.R.C.P., 64, Welbeck Street, W.
ROSS, F. W. FORBES, M.D.Ed., Chepstow Place, Bayswater, W.
SECCOMBE, P. J., M.B., B.C.Camb., 45, Madley Road, Ealing, W.
SHERHAN, J. C., L.R.C.P. & S.Edin., 129, Ladbrooke Grove, W.
SMITH, G. COCKBURN, M.D.Brux., M.R.C.S., 5, Inverness Gardens, Kensington, W.
SNOW, HERBERT, M.D.Lond, 6. Gloucester Place, Portman Square, W.
STURGE, H. HAVELOCK, M.R.C.S., L.S.A., 81, Elgin Avenue, W.
TURNER, G. R., F.R.C.S., 49, Green Street, Park Lane, W.
WALKER, A. H., M.B., M.C.Ed., Thorncroft High Road, Chiswick.
WATERHOUSE, H. E., F.R.C.S., 81, Wimpole Street, W.
WILLIAMS, L. W., M.R.C.S., L.R.C.P., 128, Mansfield Road, Gospel Oak, N.W.
WILLIAMS, M. MONIER, M.R.C.S., L.R.C.P., 20, Onslow Gardens, S.W.
WILMER, C. H., M.R.C.S., L.R.C.P., Narborough, Leicestershire.
WOAKES, CLAUD, M.R.C.S., L.R.C.P., 78, Harley Street, W.
WOODHOUSE, W. M., M.R.C.S., L.R.C.P., Kensington Infirmary, W.

Miscellaneous Extracts.

SYMPTOMS PRODUCED BY ADENOID VEGETATIONS IN YOUNG INFANTS.—Lubet-Barbon (*Mal de l'Enf.*) reports that in a child of one month the symptoms presented were that it could not breathe while nursing, and while nursing was frequently seized with attacks of coughing. It did not gain in weight, breathed with mouth open and had a constant muco-purulent discharge from the nostrils. In another case, a child aged sixteen months, there were difficult respiration, mouth-breathing, dryness of the lips, the face of violet hue; the respiration was noisy, hoarse, frequent, such as to closely simulate the respiration in a case of croup. The child has never been able to take the breast or nursing bottle, but had been fed from a glass. Cough was frequent and often caused vomiting. In another case there was considerable emphysema. Four cases are reported. In all, the treatment consisted of removing the growth by means of forceps of a particular model. The operation was performed at several sittings. In all complete recovery or great improvement followed.

GASTRIC CRISES IN DIABETES MELLITUS.—Grube (*Munch. Med. Woch.*) gives the name of "gastric crises" to the attacks which occur not infrequently in diabetes, coming on suddenly with vomiting, colicky pains, dry and coated tongue, cramp in the legs, and slight fever. Diarrhœa sometimes occurs. The attacks last from several hours to several days. Grube thinks the attacks represent a form of diabetic intoxication, in which

the vagi are irritated by toxins circulating in the blood. Under proper treatment, recovery is the rule. The most important thing is to cause copious stools by means of enemata. Hot applications to the abdomen are also useful. The vomited matter consists generally of the undigested meal previously taken.—*Modern Medicine.*

SYMPHYSEOTOMY.—Dr. Mayariet (*L'Obstétrique*, January, 1896) says that the statistics of these cases are as yet somewhat discouraging. Neugebauer gives a maternal mortality of 11·1 per cent., and that of the child 19 per cent. The operations of M. Pinard and his followers in the last four years have given a mortality of 10·14 per cent. for the mothers and of 11·59 per cent. for the children. Perhaps this mortality would diminish considerably if all operators were careful and abstained from interfering whenever any unfavourable condition exists in mother or child which would compromise the success of the operation.

ALCOHOLISM IN EUROPE AND ITS RELATION TO INSANITY.—Dr. Darin states, in a paper recently published in his *Thèse de la Faculté de Paris*, No. 219, that alcoholism is increasing in Italy and Belgium, and especially in France, while it is decreasing in Norway, Switzerland, and Germany. The number of lunatics in France has also increased. This increase has been chiefly in the two types of insanity known as alcoholic mania and general paralysis. This relation between alcoholism and insanity is shown by the statistics of different portions of the country, insanity being most common where alcoholism is most pronounced. The hereditary effects of alcohol are also striking. According to Legrain, among 814 children of alcoholic parentage, 322 were degenerates and 174 had not sufficient vitality to live. Among the survivors are 14 per cent. of hysterics and 17 per cent. of epileptics. General paresis has increased in Paris in proportion to the frequency of alcoholism.

RISE OF TEMPERATURE AFTER LABOUR.—Dr. Machure (*The Canadian Practitioner*, August, 1896) says: For twenty-four or thirty-six hours after labour, the temperature may be raised as the result of fatigue, but if the subsequent temperature should be above 99° F., its cause should always be promptly investigated. It may be due to (1) constipation; (2) mammary disturbances; (3) intercurrent non-obstetric disease; or (4) sepsis.

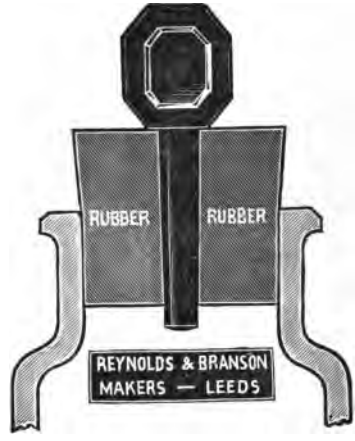
THE PATHOLOGY OF THE DIARRHŒAL DISORDERS OF CHILDHOOD.—Baginsky (*Berliner klinische Wochenschrift*, January 11, 1897, p. 22) expresses himself of the opinion that the diarrhœal disorders of childhood occurring in conjunction with elevated summer temperature, appear first as functional (chemical) disturbances and subsequently as profound organic lesions of the intestinal wall. For the development of these conditions the ordinary saprophytic bacteria of the intestinal contents and not specific bacteria must be held responsible. The active organisms cause injury to the intestinal walls through the putrefactive processes of toxic character or through products usually non-toxic in character (ammonia and its derivatives), inasmuch as they act as inflammatory irritants; or they cause degeneration of the vegetative and the most important excretory organs (liver, kidneys, &c.) through the blood stream and the lymph stream. As a result of the interference with nutrition and the diminution in the resistance of the tissues thus brought about, the organism is exposed to the invasion of pathogenic bacteria of all kinds (staphylococci, streptococci, pneumococci, oidium albicans, &c.). There also results a predisposition to disease, as manifested by numerous complications.

NOTES ON NEW PREPARATIONS, &c.

Red Gum "Tabloids." Burroughs, Wellcome & Co.—This well-known drug, long known as a mild styptic and antiseptic, and as an excellent local and general astringent, has recently been prepared in "tabloid" form, after an improved formula, with the result that the full therapeutic effect of the drug may be obtained without offending the palate or affecting the appetite. When a Red Gum "Tabloid" dissolves slowly in the mouth, the continuous action of the drug on the mucous membrane of the throat is fully secured.

Male Nurses' (Temperance) Association.—We have received the report of this Association, and learn that the last year was a most successful one. The staff has been more than doubled, and more than 100 male nurses are now in constant employment. As a proof of the keen interest which the Association takes in the welfare of the nurses, a sick fund has been established to provide for the nurses during illness. The average earnings of each man has been at the rate of over £100 after paying all expenses.

A New Rubber Cork.—Messrs. Reynolds & Branson have introduced a rubber cork which will be found very useful. As shown in the accompanying illustration, through the centre of the cork is a hole which allows the escape of air that would otherwise be compressed when the bottle is corked. The cork being *in situ*, into this hole is then plunged the glass or vulcanite plug, which not only renders the cork air-tight, but which, by widening its diameter, renders it also more secure.



"Saxin" is the name given to a powerful sweetening agent recently introduced and issued in "tabloid" form by Burroughs, Wellcome & Co. It possesses a sweetening power about six hundred times greater than that of sugar, and is most delicate in flavour. A ¼ gr. "Saxin Tabloid" may be substituted for each lump of sugar in the case of patients suffering from diabetes, gout, obesity, glycosuria, &c., since "Saxin" has no harmful action on the system.

Bipalatinoids of Creasote. Messrs. Oppenheimer & Co.—We have received a sample of these bipalatinoids, and find that the creasote is non-irritating; in 1 minim doses after food it is found to be practically a specific for furunculosis. The advantages of the bipalatinoid form of administering fluid drugs cannot be over-estimated.

Notes and News.

DURING the quarter just passed the air was thick with everything "jubilous" in commemoration of Her Most Gracious Majesty's glorious reign. The all-pervading excitement about the Jubilee was such that both consultants and general practitioners felt its full effects, not in an increase, but in a diminution of patients. Their experience, curiously enough, was amply confirmed by the Registrar-General. This excellent official, a week or so before the great event, was able to bring out quite a Jubilee number of his weekly returns. The mortality rate during the period in question in London fell to the phenomenally low figure of 13·4 per 1,000. As a matter of fact, it would seem that no one had had time to be ill; all had made up their minds to take part in the Jubilee celebrations, or at all events, to be alive and well at the time. But the great day has passed; a day which in the splendour of its pageantry, the universality of the rejoicing, the unique display of the national greatness has never been eclipsed in the history of the nation, and its record is likely to remain unbroken for many a generation to come.

IT had occurred to me to have brought out a "Jubilee" number of our JOURNAL. But out of consideration for the members of the Society, I refrained from doing so. It would not, of course, have followed the same lines as those of the *British Medical Journal* and the *Practitioner*, the Jubilee numbers of which have been such a conspicuous success. But I should have introduced certain novelties, adapted to the size and space of our JOURNAL, in which an endeavour would have been made to sound the note of jubilation with just the same degree of genuine *eclat* as was the case with the journals above-mentioned.

I HAVE received the following from an esteemed colleague:—

"Two young gentlemen, Dr. Churchhill Dunn and Mr. Nunn, were to-day (June 25) candidates for the House Physiciancy at the West London Hospital, which suggested the following:—

> "Said Dunn, 'If Nunn beats me I will not complain,
> For I shall be second to Nunn.'
> Cried Nunn, 'If I lose, I also shall gain,
> Because, should Dunn win, I *am* done.'

"Is this good enough for the 'Notes and News' of the WEST LONDON MEDICAL JOURNAL?"

IT is. But it is rather late for the Jubilee honours list. Some little assistance seems to be required in the Poet

Laureate department, and the above "ode" might have suggested a new appointment in this connection had its publication appeared a little earlier. Nevertheless, however this may be, it seems to demand an answer:

"Good colleague, your wit is essential
To our meetings, our dinners, and—such,
But, like Nunn,
I am done—
Quite un-done—
In having nothing to rhyme with—such."

THE Cavendish Lodge continues to make gratifying progress. At the meeting held in June last, Brother Vivian was raised to the degree of Master Mason; and Brother T. Gunton Alderton, our Treasurer, was passed to the second degree, while Mr. Edward Somerset Eccles was admitted into Freemasonry. The S.W. (Brother P. S. Abraham) was unanimously appointed Worshipful Master-Elect, and Brother J. Herbert Menzies was re-elected Treasurer of the Lodge. The next meeting will be held on the third Wednesday in October next.

THE session now drawing to a close has been especially fruitful in good papers. Their standard of excellence has been high, and they have led to well sustained and instructive discussions. It would be too invidious to mention any by name, but the fact of the papers being good will be apparent to all who peruse the numbers of the JOURNAL in which the proceedings have been fully recorded. The pressure on our space however, owing to the publication of the Cavendish Lecture, has unavoidably compelled me to hold over certain contributions till the October number.

FROM a medical point of view one of the most noteworthy changes effected during the Queen's Record Reign has been the lapse of venesection as a therapeutic measure. The wonder is how, even sixty years ago, patients consented to part with so much of their blood—say after an operation—and yet survived, or, at all events, some of them. Apropos of this subject I came across recently a curious passage in the "Romance of London," by John Timbs. In an article upon the State Lotteries, which were abolished in 1826, it is stated that "the Guildhall was a scene of great excitement during the time of the drawing of the prizes there, and it is recorded that poor medical practitioners used constantly to attend, to be ready to let blood in cases when the sudden proclaiming of the fate of tickets had an overpowering effect." Even imagination can scarcely picture such a scene here portrayed in the present day. The "poor" practitioners, sad to relate, still exist as a class; but for many years, venesection not being fashionable, they have had to supplement their incomes

by other means than by "letting blood" on occasions of public excitement. The change in the times has been such that medical men now-a-days are very solicitous in regard to the loss of blood by a patient, and, not to be behindhand, the patients exercise the same careful regard in respect to the expenditure of fees for professional services.

THE Annual Dinner of the Society was held at the "Trocadero" on May 28, the President, Mr. Bruce-Clarke, in the chair. He was supported on the right by Lord Lister and the Director-General of the Army Medical Department, and on the left by Sir John Williams, at that time the Cavendish Lecturer-Elect. The number present nearly reached "three figures," but the pleasantness of the evening was sadly marred by the heat. The only persons who looked cool were the band; it was evident, therefore, that the physical exertion of trying to cause emphysema of the lungs was less exacting than than that of eating a dinner. But this brings me to a point which is worthy of mention. Why should the Annual Dinner always be held in the summer solstice. The expiring energies of the members of the Society, after a long and arduous session, cannot be fanned into new life by the prospect of a seven-and-sixpenny dinner (without wine), eaten to the accompaniment of the conditions of a Turkish bath. Nor can there be, under these circumstances, much enthusiasm in connection with the entertainment. The Council, therefore, might well consider the desirability and expediency of fixing the dinner for some day in the month, say, of October, when there would be less perspiring, more enthusiasm, and a greater opportunity of a larger attendance.

THE Dance in aid of the West London Hospital took place at the Queen's Hall, Langham Place, on Monday, May 31, when many friends of the hospital, members of the Society, foregathered and largely contributed to the success of the evening. Nearly 500 tickets were sold, and out of this number there were few absentees.

WHETHER the policy of postponing, till November next, the Festival Dinner of the West London Hospital, which had been fixed for July 7, has been a wise one, time only can show. By general consent, however, as far as I can hear, the decision has been condemned, more especially since the reports of the excellent Secretary, Mr. Gilbert, had been highly favourable with respect to the progress of the subscription list. The initial mistake, of course, was accepting a date for the Dinner *after* the Jubilee. The time when such a festival meeting would be likely to be auspicious would naturally be before the day of the national rejoicing, and this fact must have been clearly recognised by other hospital managers, for during the

first five months of the year it was curious to note the oft-recurring announcement in the daily press referring to this, that and the other hospital whose Festival Dinner had been successfully held. It is regretful to think, then, that the West London may have lost its opportunity of securing some of the "pickings" which the Jubilee period rendered available for hospital charities. The philanthropic public is a fickle one to deal with; it is moved entirely by sentiment, and its purse-strings are mainly unloosed in favour of that object which at the time excites its special interest.

But many things may happen before November, and the promises of support which the so far abortive festival in aid of the West London have called forth, may be annulled, before the dinner is held, in favour of some pressing new fund to which every one with money to spare will consider it his duty to contribute.

To beg money successfully from the public for a charity is undeniably an art, in which enterprise, business capacity, energy, and tact, form some, at least, of the most important features. Meanwhile the new wing at the West London, which the Prince and Princess of Wales and "other members of the Royal Family" visited last year, still remains empty and unadorned with patients. At present it would seem to be rather a melancholy monument of incapacity of some sort. When will it be opened? Echo answers—when?

Did the immortal Shakespeare know anything about appendicitis? It might appear to be so from the following quotation taken from the "Taming of the Shrew,"—"My master hath appointed me to go to St. Luke's to bid the priest be ready to come against you come with your appendix." Reading between the lines the inference might be that some one had organised an exhibition of patients who had successfully survived the removal of their appendices—the latter being also on view as "pickled" specimens—the attraction of the show being that each patient exhibited his (or her) own appendix, or all that portion of it which had been removed, preserved in a chaste design of "pickle" bottle, tastefully adorned with ribbons of the jubilee colours of the period. Unfortunately, however, for this theory, the context shows that Shakespeare was not referring to the Eldorado of modern surgery. He simply meant by "appendix" Lucentio's to-be-wedded young woman, Bianca. Katherine, in a peroration afterwards, refers to such appendices as "froward and unable worms;" in some degree the description is not inapplicable to the "appendices" with which surgeons have now to deal.

P. D.

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THE

West London Medical Journal.

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Original Communications.

RECENT PROGRESS IN ASEPTIC SURGERY.

By W. Bruce Clarke, M.B., F.R.C.S.

Assistant Surgeon to St. Bartholomew's Hospital.

Being the retiring Presidential Address.[1]

When I entered on this presidential chair, now nearly a year ago, I ventured to draw your attention to the importance of muscular exercise in the treatment of certain forms of disease. To-night, with your permission, I am going to refer to some points which I hope may enable us ultimately to carry even to greater perfection than it has at present attained to, the treatment of various infective disorders. Primarily, of course, as a surgeon, I am referring to traumatic infection, but the modes by which this infection is conveyed, and the means which are taken to combat it, when applied to other infective conditions, have already done a great deal to rid us of their scourge, and will be attended by some greater success in the near future.

[1] This address was delivered before the Society at the annual meeting on July 16, 1897.

When the International Medical Congress met in Berlin, in 1890, we surgeons were many of us startled by the demonstrations of aseptic wound treatment adopted at the hands of Von Bergmann and his assistant Schimmelbusch. The principle was no doubt an excellent one, but we had still to learn that it was an easy one to carry out. I need not allude to the steps, with which you are familiar, which have culminated in the use of a boiler of some sort by almost every practitioner for the cleansing of his instruments. No one who has used such a simple piece of apparatus can fail to testify to its advantages, and its simplicity leaves almost nothing to be desired. Boil everything you are about to use that can be boiled without damage.

But there are other sources of infection, to which attention was soon called, and first let me refer to the organisms of the skin. Amongst the first to study the question and to call attention to it were Kümmell and Fürbringer. It is curious to look back a few years earlier, 1882, and to find Cheyne asserting that washing with soap and water is unnecessary. Such views were soon dissipated by Fürbringer, who showed that even the strongest antiseptics often failed to attack bacilli clothed, surrounded and protected by grease. It is with a view to getting rid of this unctuous mass that abundant soap and water, turpentine, alcohol and ether are now employed for skin cleansing. But it must be carefully borne in mind that the efficiency of the method employed can only be satisfactorily tested by experiment. Cultivation experiments must be made use of, *i.e.*, taking small portions of the skin, both of the surgeon and his patient, and ascertaining if these portions are free from infective agents by placing them in sterilised broth. One of the first surgeons in England to draw attention to this method was my old friend and colleague, Mr. Lockwood; and there can be no doubt of the value of his suggestion.

The purification of the skin demands the utmost care on the part of the surgeon, and it is doubtful whether any means or any substances at present at our disposal can be regarded as absolutely infallible. Some of the best results may be got by soaking the hands from one to two minutes in a solution of 1 in 500 of biniodide of mercury in 75 per cent. rectified spirit, to which a little water and iodide of potassium have

been added to dissolve the biniodide (Lockwood). I have found a solution of izal, 1 in 100, preceded by abundance of soft soap and water, equally efficacious, and far less likely to damage the integrity of the skin, which, as I shall proceed to point out, is a matter of great importance. Every one who has employed antiseptics for his hands is aware that when used in certain strengths they are sure to give rise to roughness and harshness of the skin, a condition which is reached in some individuals with far less provocation than it is in others, but I don't think the fact is generally appreciated that such roughened hands are far more difficult to make aseptic than are hands which have not been subjected to such powerful disinfecting agents, and yet such is undoubtedly the case. Another point which well merits our attention is the fact that though the surface of the skin is often pure in the neighbourhood of a wound when it is inflicted, it does not remain so when the wound has healed. Indeed, the bacteria of the skin are often found in close proximity to a wound which has healed by first intention, and my own observations would lead me to believe that this is more likely to be the case when the skin has been subjected to such a vigorous cleansing as to induce vesication. In all probability the presence of such bacilli is to be explained by their emergence from the skin glands whilst the healing process was proceeding. If this be a correct explanation of the facts, it is hardly needful to point out that the outpouring of fluid from the deeper tissues by vesication is a process which should be carefully avoided.

If the so-called healthy skin is difficult to purify, still greater care is demanded to prevent infection by the hands of the surgeon, when he has recently been handling any infective material. Purification under these circumstances may often prove to be of the very greatest importance, as the following instance will show: It is now some four or five years ago that I was called to see a case of extravasation of urine, which demanded, of course, energetic incision, and involved a considerable fouling of one's own hands. Within an hour of completing this I was summoned to the hospital to a severe smash of the arm and forearm which had exposed the elbow joint and severed one of the nerves, I forget which, and lacerated the surrounding structures to a considerable extent.

I need hardly assure you that it was with some misgivings that I undertook the case, and that I did not touch it until I had purified my hands with abundant washings in soft soap and water, and had soaked them in various antiseptics, amongst which I remember was 1 in 500 sublimate. Sufficient to add, the nerve was sutured, and the various torn structures carefully re-adjusted, and the patient made an uninterrupted and good recovery, which resulted in an arm as perfect in every movement as it had been before the accident. Culture experiments with one's fingers were then unheard of, or at least deemed unnecessary, so that there is no absolute proof that my hands had been rendered bacteriologically clean, but at least it is certain that they were sufficiently pure not to damage to any obvious extent the tissues of my patient. One cannot too forcibly insist on the fact that it is possible to cleanse one's hands by careful washing, and by disinfectants of septic matter, for in the course of one's practice one is often called on to pass with some rapidity from a foul to a pure wound, and were it not for the confidence which such experiences give one it would be difficult to find any pleasure in one's daily round of work. No thoughtful surgeon would wantonly pass from a stinking case of gangrene to a freshly incised surface, but he will find much consolation in remembering that if he is forced to do so, his patient need not suffer if he take proper precautions to cleanse his hands.

So far I have alluded only to two sorts of infection: (1) Infection by instruments; (2) Infection at the hands of the surgeon. There still remain two other sources: (3) Infection through the air; (4) Infection of a patient by poisonous matters in his own body.

In the early days of antiseptics, the air, as we all know, was looked upon with great suspicion, and the spray was regarded as an efficient protection. Recently it has been the fashion to decry the part which the air takes in wound infection, and from a practical point of view probably this is in the main correct. Thanks to the protective influence of our own tissues, which I will allude to later on, and the abundant use of antiseptic washes in our wounds, infection rarely finds its way through the medium of the air, but no one who reflects on the matter can for one moment doubt that the air contains abundant infective material. Tyndall's experiments many years ago set at rest for ever any question of doubt as to the infec-

tive possibilities of the air, but experience soon demonstrated that the spray was of little practical service in destroying its infective material, and this cumbrous accompaniment of antiseptic surgery was quickly discarded for more simple methods. But we may yet have to review our ideas of the possibilities of air infection. Quite recently a valuable paper on this subject has been contributed by Waring to the St. Bartholomew's Hospital Reports, vol. xxix., in which he shows that various cultivating materials, when exposed to the air of hospital wards and operating theatres, are quite capable of demonstrating the presence of staphylococcus pyogenes aureus, and other noxious germs.

What is it, then, that protects us from their ravages? To understand this point we must first consider how far we are capable of infecting ourselves by our own secretions, and what doses we can tolerate without harm. No certain and absolute answer can be given to these questions, but we have abundant materials at our hand to show us that it is here we must seek for an explanation of such immunity from infection as we have at present attained to. Here is a rich harvest for the investigator waiting to be gathered in, which will enable us fully to understand much which at present we only see feebly glimmering in the distance. I doubt not that in the near future we shall learn what the factors are that render our bodies immune at one time and vulnerable at another, and shall clearly understand the process by which, as the end of our mortal existence is approached, our vulnerability increases until at length we are oftentimes lulled into our last sleep by the toxic and anæsthetic properties of our own self-manufactured poisons.

The subject of immunity is even now an extensive one, and were I to attempt to even skim over all the points which it involves, I should carry you far beyond the limits of a short address. But the point to which I specially wish to call attention is to the use and usefulness—which, by the way, are two very different things—of various antitoxins. I will confine my attention here to the antitoxins of the various traumatic infective fevers, such, for example, as antistreptococcus serum. In a recent paper read before the Medico-Chirurgical Society,[1] Mr. Herbert Durham goes so far as to propose that

[1] Med.-Chir. *Trans.*, vol. lxxx., part ii., p. 191.

before operating on the peritoneum of a patient who is supposed to have some special variety of peritonitis, the corresponding antitoxin should be administered. There are, as indeed he points out, obvious difficulties involved in the carrying out of such a plan, viz., the diagnosis of which particular antitoxin is required, but I would venture to suggest that some such plan of procedure may enable the surgeon to tide the patient on whom he has operated over the first few critical days, when he is in danger of dying, as we sometimes say, of shock.

Do we ever reflect what we mean by this word? I doubt it. It is a convenient term to express the clinical fact that our patient's vital powers are being sapped by something, it may be by a sympathetic nerve paralysis, loss of blood, some virulent animal poison, or possibly by other causes, of which as yet we have no conception. It is to dissipate this so-called shock *when* it is caused by a toxin that we need a corresponding antitoxin. How often has one drained and washed out an abdomen for an attack of acute peritonitis and felt that if only one could keep the patient alive for twenty-four hours he would possibly recover. Operative surgery may do something for such cases. It has already been attended with a certain amount of success, but, as the surgeon frequently expresses it, the patient has gone too far before he has been given a chance. And there is another side to the question—the physician may call in the surgeon to tide over a difficulty by operation, until his remedies can have their full swing. Only within the last forty-eight hours I have had an excellent illustration of this in the case of a child suffering from diphtheria, which I am seeing with Dr. Ball and Mr. Menzies, for which I was asked to perform tracheotomy, so as to tide over the difficulty of breathing, in order to allow the diphtheria antitoxin time to exercise its sway. Of the ultimate result I can, of course, say nothing as yet, but the principle involved is, I have no doubt, a corrective. And this brings me to another point, viz., the need for standardising the various antitoxic sera. In the case of the diphtheria antitoxin this has already been to a certain extent adopted, but much yet remains to be done, and if we are to use powerful remedies of this nature with the success which they ought to and will eventually command, a ready way must be

found by which we may be enabled to estimate at least approximately what amount of antitoxin may in each case be safely given. To arrive at this conclusion it will be necessary first to ascertain the lethal dose of a toxin per unit of body weight by experiment on animals; and secondly, what dose of antitoxin is capable of neutralising the corresponding dose of toxin within an ascertained time limit. Unless this latter factor be determined, our patient will be in danger of slipping through our fingers before the opposing antitoxic forces can exert their full influence; or, to put the matter more simply, if a patient's condition is so serious that in our opinion he cannot survive many hours, a larger dose of antitoxin must be administered, because if it is to do any good it must work with greater rapidity. What increase may safely be administered under such circumstances? Mathematicians will tell us this is a simple matter of a formula and an equation. It may be so, but the formula, or as most of us would call it, the prescription, must be determined, no doubt, partly by experiment and by reasoning, but very largely by the personal experience of the practitioner in each case.

It is with feelings of regret at our own imperfections that we must cease from pursuing this inquiry further to-night, but with a confidence that progress awaits us. It is with similar feelings that I quit this chair, thankful for the courtesy you have all extended to me during the past year, and with a like confidence that similar progress will attend this Society in the hands of my successors.

Intestinal Fermentation.—In a study of the various foods as to their putrefactive tendencies, Gilbert and Dominici experimented with milk upon a healthy man. Two and five-tenths litres of milk were given daily for five days. Before beginning with the milk diet the fæces showed sixty-seven thousand bacteria per milligramme. On the second day of the milk diet the fæces showed fourteen thousand bacteria; on the fifth day, twenty-five hundred. By the use of sterilised milk the number was still further reduced. From this the inference is drawn that milk is the ideal diet in typhoid fever and other diseases, it being less fermentative than meat and other albuminous materials.

TWELVE MONTHS' GYNÆCOLOGICAL WORK.[1]

By J. A. Mansell Moullin, M.B., M.R.C.P.

Physician for Diseases of Women, West London Hospital; Physician to the Hospital for Women (Soho Square).

During the past twelve months I have had occasion to perform laparotomy for various reasons in some forty cases. I have tabulated them below in their order of sequence; their number does not permit any other arrangement.

Of this number eighteen were performed at the West London Hospital; and here let me express my best thanks to Mr. E. W. Lewis, Mr. Alderton, Mr. Keenan, Dr. Fancourt Barnes, Dr. Benjafield, Mr. Whitington, Mr. Disney Roe, and all those who have kindly sent up cases to the hospital.

The list includes sixteen cases of ovariotomy for cystic disease, all of which have done well. Some of these cases were favourable, others decidedly unfavourable, and all conditions of ruptured cyst, twisted pedicle, and dense adhesions were met with. It is very seldom, however, that the operation for removal of cystic ovaries presents difficulties which cannot be surmounted. The danger of sepsis being now a phantom, the mortality from this operation has been reduced almost to vanishing point.

Included in this number are those cases of cyst of the broad ligament which were pedunculated, and so might for all practical purposes have been cyst of the ovary. Three others which were sessile, and burrowing into the ligament, and owing to the thinness of their walls or extent of their connection could not be enucleated, were stitched to the parietes and drained.

Six cases of hæmatocele are included in the list. Most of these are recorded in a paper on "Intra-Peritoneal Hæmorrhage, in Connection with Tubal Pregnancy, which I read before the Society (West London Medical Journal, vol. ii., No. 1, January, 1897). One case, which terminated fatally, confirms me still more strongly in the belief that early operation,

[1] Post-Graduate Lecture delivered at the West London Hospital on June 9, 1897.

No. of Case.	Date of Operation.	Medical Attendant.	Name.	Age.	Nature of Case.	Result.	Remarks.
1	Feb. 20, 1896	Hospital for Women Mr. C. Disney Roe, Holloway	S. C.	26	Hæmatocele ...	R	Small intra-peritoneal hæmatocele. Right ovary and tube, containing a small ovum, removed intact. Left ovary cystic, removed same time
2	Mar. 13, 1896	West London Hospital	E. H.	37	Broad ligament cyst ...	D	Much shock after operation; never rallied
3	Mar. 23, 1896	Hospital for Women ...	A. McM.	26	Hæmatocele ...	R	Left ovary and tube bound down by adhesions and old blood clot, removed. Mucous lining of tube thickened, but no ovum discovered. Right side healthy
4	April 23, 1896	Hospital for Women ...	E. H.	27	Broad ligament cyst ...	R	Stitched to abdominal parietes and drained
5	April 27, 1896	Hospital for Women ...	A. C.	36	Ovariotomy ...	R	Large fibroid tumour of right ovary. Left also diseased and removed
6	May 4, 1896	Hospital for Women, Dr. J. C. Giles, Cambridge	M. D.	29	Ovariotomy ...	R	Both ovaries cystic and removed
7	May 7, 1896	Hospital for Women ...	R. C.	29	Ovariotomy ...	R	Dermoid tumour right ovary, removed
8	May 7, 1896	Hospital for Women ...	E. R.	29	Hæmatocele ...	R	Large hæmatocele right side flushed out
9	May 20, 1896	Dr. Benjafield, Edmonton	J. C.	30	Hæmatocele ...	D	Hæmotocele left side. Patient in critical condition. Clot offensive. Flushed out as well as possible and closed wound. Died three days later
10	May 26, 1896	West London Hospital	E. P.	71	Ovariotomy ...	R	Large cyst right ovary, removed
11	May 28, 1896	Hospital for Women ...	R. C.	50	Hysterectomy ...	D	Large multiple fibroid. Uterine arteries ligatured. Stump sewn with catgut and returned. Died 48 hours later. No obvious cause, *post-mortem*. Liver fatty
12	May 29, 1896	West London Hospital	H. L.	38	Ovariotomy ...	R	Both ovaries cystic and removed
13	June 9, 1896	West London Hospital	L. U.	24	Ovariotomy ...	R	Both ovaries cystic and generally adherent, removed
14	June 12, 1896	West London Hospital	A. L.	41	Ovariotomy ...	R	Broad ligament cyst with pedicle
15	June 19, 1896	Dr. Crabb, Holloway	A. W.	43	Ovariotomy ...	R	Left ovary cystic
16	June 25, 1896	Dr. Cameron, Balham	A. S.	36	Ovariotomy ...	R	Right ovary cystic
17	June 26, 1896	West London Hospital	E. McG.	39	Hysterectomy ...	D	Extra-peritoneal with *serre-nœud*. Clotting of sinuses at base of uterus made operation extremely difficult. Death third day. Delirium tremens

No. of Case.	Date of Operation.	Medical Attendant.	Name.	Age.	Nature of Case.	Result.	Remarks.
18	July 4, 1896	West London Hospital, Mr. E. W. Lewis, Hammersmith.	F. G.	22	Cæsarean section ...	R	Pelvic contraction due to rickets. Child dead. Case reported *West London Medical Journal*, Vol. I., No. 4, October, 1896
19	July 14, 1896	Hospital for Women ...	E. H.	33	Ovariotomy ...	R	
20	Aug. 4, 1896	West London Hospital	H. S.	40	Hæmatocele ...	R	Blood cyst size of egg, adherent to fimbriated extremity of right Fallopian tube. Cyst, tube, and ovary removed entire
21	Aug. 21, 1896	West London Hospital	R. D.	23	Hæmatocele ...	R	Probably intra-peritoneal and coming from left ovary, which was much enlarged by contained clot. Flushed out and appendages removed both sides.
22	Oct. 9, 1896	West London Hospital	K. N.	19	Exploratory operation	R	Salpingitis and general adhesions. Appendages too fixed to permit removal
23	Nov. 17, 1866	West London Hospital	L. H.	36	Ovariotomy ...	R	Cyst of right ovary intimately adherent to parietes in front, tapped, emptied and posterior wall opened. Adhesion thus got at from behind. Left ovary also cystic and removed
24	Nov. 25, 1896	Mr. Whitington, Tuxford	F. A.	33	Ovariotomy ...	R	Multilocular cyst, right side
25	Dec. 14, 1896	Hospital for Women ...	E. L.	46	Vaginal hysterectomy	R	Cancer of cervix had already invaded ligament on left side. Body not involved. Recovery uneventful
26	Jan. 1, 1897	Mr. Whitington, Tuxford	E. T.	28	Porro's operation ...	R	Head of child large and unable to enter brim of pelvis, which was also contracted. Child dead.
27	Jan. 22, 1897	West London Hospital, Mr. Alderton, Hammersmith	G. P.	29	Pedunculated fibroid ...	R	Treated extra-peritoneally with *serre-nœud*
28	Jan. 29, 1897	West London Hospital	K. F.	25	Broad ligament cyst ...	R	Stitched to parietes and drained
29	Feb. 11, 1897	West London Hospital	E. R.	24	Pedunculated fibroid ...	R	Small pedicle ligatured and returned
30	Feb. 23, 1897	West London Hospital, Mr. Keenan, Putney	S. F.	17	Ovariotomy ...	R	Multilocular cyst of left ovary with ascites

No. of Case.	Date of Operation.	Medical Attendant.	Name.	Age.	Nature of Case.	Result.	Remarks.
31	Feb. 25, 1897	Hospital for Women, Mr. Whitington, Tuxford	M. G.	48	Hysterectomy ...	R	Modified Schroeder's operation. Stump brought up to abdominal wound, and parietal peritoneum fixed round it. Aponeurotic structures closed over stump. Stump sloughed, much trouble and time elapsed removing slough and buried sutures
32	Mar. 4, 1897	Hospital for Women, Mr. Whitington, Tuxford	M. G.	52	Hysterectomy ...	R	As preceding case. Union by first intention
33	Mar. 12, 1897	West London Hospital, Mr. Keenan, Putney	M. C.	36	Ovariotomy ...	R	Dermoid cyst of right ovary with twisted pedicle
34	Mar. 22, 1897	Hospital for Women ...	E. C.	42	Removal of appendages	R	On left side a small cyst, probably of ovary, containing broken-down material. Tube thickened and adherent, removed.
35	Mar. 25, 1897	Hospital for Women ...	A. H.	28	Ovariotomy ...	R	Dermoid cyst of right ovary, with teeth, &c. Pregnant three months, miscarried.
36	Mar. 25, 1897	Hospital for Women, Mr. Lightburne, Bow Road	E. S.	30	Removal of appendages	R	Old standing and dense adhesions of omentum to parietes and front of uterus. Left ovary enucleated and removed. On right side, normal
37	Mar. 27, 1897	Hospital for Women ...	M. W.	36	Removal of appendages	R	Both ovaries firmly adherent to back of uterus, removed with tubes. A firm adhesion of sigmoid to fundus uteri allowed to remain
38	Mar. 29, 1897	Hospital for Women ...	R. B.	27	Removal of appendages	R	Uterus retroflexed and bound down. Ovaries intimately adherent and enucleated with difficulty. Tubes, chronically thickened and closed, removed, at same time. Pedicles short, operation difficult and prolonged.
39	April 1, 1897	Hospital for Women ...	S. F.	45	Hysterectomy ...	R	Large multinodular tumour. Treated extra-peritoneally with *serre-nœud*
40	April 9, 1897	West London Hospital, Dr. Bridger, Portland Place	L. H.	22	Ovariotomy ...	R	Cyst of right ovary removed

which I advocated in that paper, is the best treatment in all cases of hæmatocele. I had no difficulty in recognising the nature of the case, and arranged to operate the day after the next. Some days had already lapsed since the attack. At the time of operation her condition was far from satisfactory. The abdomen was distended and excessively tender, and there was evidently considerable peritonitis. I found the effused clot had become septic, and was decidedly offensive. I flushed out the cavity with an abundance of water and closed the wound. Had the patient been in hospital I should have preferred to drain; but I do not imagine it would have made any difference in the ultimate result.

Four cases are classed under the head "Removal of the Appendages." In all these the condition was one of chronic inflammation. Some of them were of long standing, and had undergone much treatment at various hands for pelvic pain and dysmenorrhœa, and had been in hospital repeatedly. In all, the ovaries and tubes were firmly bound down and adherent to the uterus and neighbouring organs. The greatest difficulty was experienced in enucleating and digging them out. In one case, classed as an "exploratory operation," this was found impossible. The operation presents much greater difficulties than when the ovaries are removed for cystoma, and I have preferred to place them in a separate list.

Cæsarean section is represented by one case already published in the Society's JOURNAL (vol. i., No. 4, October, 1896). On January 1, 1897, I was sent for by Mr. Whitington to operate in a case where other means, forceps and turning, had been tried without success. The patient was a small woman, and the conjugate diameter of the pelvis further narrowed by some projection of the promontory of the sacrum. Neither the head nor the breech could engage the brim of the pelvis. The operation, in which I had the able assistance of Mr. Whitington and Dr. Thomson, of Retford, presented no special difficulties. The uterus was opened without hæmorrhage. The child, which was dead, was of enormous size. The uterine walls were exceptionally thick, and for this reason, and also fearing there might be considerable bruising of the parts, I decided upon Porro's operation, and removed the uterus, instead of Cæsarean section. The patient made an excellent recovery, but the protracted con-

valescence of the extra-peritoneal method compares unfavourably with the more brilliant results of the Cæsarean operation; and when there is an option in the matter, I have little doubt that the Cæsarean section will commend itself increasingly in the future.

Two cases of sub-peritoneal pedunculated fibroids, one in a young married woman, 24 years of age, were treated successfully. In one case the pedicle was ligatured and returned, in the other brought outside and fixed in the wound.

Five cases of abdominal hysterectomy complete the list. These were treated by various methods. In No. 11 I ligatured the uterine arteries and completed the operation very satisfactorily, sewing the uterine flaps together and bringing the peritoneal surfaces carefully into apposition with fine catgut sutures. The stump was then allowed to fall back. The result was not a success. I am unable to account for the patient's death. There was neither hæmorrhage or peritonitis, and the *post-mortem* revealed nothing but a fatty liver.

In Nos. 31 and 32 I adopted the following method: The broad ligaments were first tied off on either side and the uterine arteries secured. The tumour was amputated by an antero-posterior V-shaped incision as near the cervix as possible. Catgut sutures were then passed through the flaps, the stump brought up to the parietal wound, and the ends of the sutures passed through the parietal peritoneum and tied. In this way the uterine cicatrix was practically extra-peritoneal. The aponeurotic structures and skin were brought together over the face of the stump by a continuous catgut suture.

In one case the wound healed by first intention, and there was not a moment's trouble or anxiety about the case from the moment of operation. In the other the result was not so good. Union was not complete. The stump sloughed and convalescence was protracted while the slough and sutures were coming away.

In No. 39 I adopted the extra-peritoneal treatment with the *serre-nœud*.

Operators have long been endeavouring to supersede the use of the clamp by some intra-peritoneal method. The use of the wire *serre-nœud* is regarded as an unscientific and unsurgical proceeding. The difficulty is the treatment of the

stump. If allowed to fall back into the peritoneal cavity it may bleed, or the bowel may become adherent to it, and give rise to trouble later on. It was to obviate these two sources of danger that I adopted the method mentioned above in cases 31 and 32. Then another difficulty arose; the stump sloughed.

After the uterine arteries are tied the circulation in the flaps is feeble and the sutures may be sufficient to strangulate them entirely. It has been proposed, therefore, to cut away the uterus altogether, just leaving the cervix, and to close the peritoneum over it. Mr. Mayo Robson, Mr. Bowreman Jessett, and other operators, are convinced that in the near future myoma of the uterus will be treated by total extirpation or panhysterectomy. I must say I do not feel so confident on this point. Panhysterectomy has dangers of its own, and I cannot do otherwise than believe that the floor of the pelvis must be seriously weakened by such an operation. On the other hand, the success of the extra-peritoneal treatment of the stump has been amply demonstrated, and, I am inclined to think, will maintain its position as the operation of election; but when for some reason or another it is not available, then I think panhysterectomy may eventually prove superior to all other methods, at least to all that have yet been tried.

On the general after-treatment of these cases I should like to make a few remarks. On returning the patient to bed the pulse and temperature are taken. The temperature after an operation is generally sub-normal, and indicates to some extent the amount of shock. When this is severe an enema of beef tea and brandy is given, and hot water bottles are applied to the feet and chest. I find the use of large enemata attended with better results than smaller. Three-quarters of a pint or more of a dilute solution of beef tea is readily retained under the circumstances, and being quickly absorbed acts as a mild kind of transfusion. As a rule the shock passes off in about a couple of hours, and the patient's skin becomes moist.

Some *retching* and *sickness* due to the anæsthetic may be expected, and while this continues it is better not to give anything by the mouth. Three or four hours after the operation I allow a cup of hot tea. Should this be returned, it will wash out the stomach, and probably put an end to

the retching. Later in the day another cup of tea may be given, and a little arrowroot in the evening. Occasionally the vomiting persists, and may be very distressing. When this is the case, keep the stomach empty. Should it be necessary, nutrient enemata may be given every four hours. A mustard leaf applied to the epigastrium sometimes has a good result. I have seen this distressing symptom instantly relieved by a hypodermic injection of morphia.

Thirst is often very troublesome on the day following an operation. I find this is relieved by hot tea more effectually than by any other means. A sliced lemon or orange to suck is greatly appreciated. Ice does not appear to relieve the thirst to the same extent, and is not very agreeable to a patient who has bad teeth, or is wearing an artificial plate. A pint of hot water injected into the rectum has been recommended, but if there is no sickness I cannot see the reason for withholding a reasonable quantity of fluid by the mouth. The practice of giving teaspoonfuls of hot water every hour appears to me only to aggravate the distress. It is as well to encourage the patient to bear with it as well as she can, and explain to her that it will pass off in the course of a few hours.

The *diet* during the first few days should be light and digestive. If the patient is going on well, some fish may be allowed on the third day. Each case must be treated according to circumstances. If the patient's condition is low, nourishing food should be given at once after the operation. Unless there are special reasons to the contrary, I am convinced the patient feels more comfortable when the stomach has something to do. Many of these patients are in other respects quite healthy, and up to the time of operation accustomed to a liberal diet. By the third day they begin to feel low and depressed if the starvation is pressed too far. The danger of overfeeding with an untrained nurse is greater than that of underfeeding, but there is no occasion for a treatment different to that required in other surgical cases.

Pain following operation is not often severe, but if sufficient to prevent the patient from sleeping, it is advisable to give a hypodermic injection—a quarter or third of a grain of morphia. Opium should never be given, unless it is absolutely required, but the antipathy to its use exhibited by some operators is just as senseless as the old practice of giving it indiscrimin-

ately in every case. Like other valuable remedies, it must be used with discretion, and not abused. I have seen the best results follow its exhibition, and a patient who was restless and unhappy, quite a different creature in a few hours. In one case a troublesome hiccough, which was exhausting the patient on the third day, was at once allayed by a quarter of a grain of morphia taken by the mouth, and in another persistent retching was speedily relieved by a hypodermic injection.

Pain in the back on the second day is not infrequently complained of, and may arise from the unaccustomed dorsal decubitus. Unless there is reason to the contrary, I allow the patient to turn on her side, when relief from the pain is soon obtained and she is able to go to sleep.

Tympanites is sometimes troublesome. The abdominal distension is not necessarily associated with, or a symptom of, peritonitis. The rectal tube is often of service, and should be retained for ten to twenty minutes at a time. Early purgation is, however, the most efficacious remedy. As a rule, I get the bowels to act on the fourth day, but if the abdomen is much distended, I do not wait. A good saline purge, repeated if necessary, or better still, a dose of castor oil, should be followed by an enema. This ensures the softening of hard scybalæ, and an easier evacuation. An accumulation in the bowel sometimes causes a rise in the temperature, which subsides at once when the bowels have been moved.

The *urine* should be drawn off six hours after the operation, and subsequently at intervals of six or eight hours, until the patient can pass it herself. The catheter should not be used longer than required, and the greatest precautions observed to keep it aseptic. Cystitis is one of the unfortunate complications which may arise during convalescence from an abdominal operation, and is generally attributed to the introduction of bacteria on an imperfectly sterilised catheter. This is probaby most often the case; but cystitis may occur independently of the use of the catheter. The patient, lying on her back, is unable to empty the bladder completely, and a certain amount of residual urine is always left behind. Germs have no difficulty in passing up the urethra, more especially the bacillus coli, which swarms on such occasions, and once it gets to the

residual urine cystitis is inevitable. The best way to treat it is to give the patient an opportunity of passing urine more readily, and to wash out the bladder with a solution of boracic acid, gr. x. to the ʒi., or boro glyceride. The simplest contrivance for the purpose is a glass funnel attached by flexible tubing to a large-eyed soft catheter. As the funnel is raised the fluid pours into the bladder by its own weight, and as it is lowered the fluid flows back again.

Peritonitis, owing to the improvements in aseptic surgery, has no longer the terrors for us it formerly had. Instead of being, as it was at one time, the most frequent cause of death, it is now happily a very rare event. Its advent is often most insidious. The first symptom to excite alarm is persistent vomiting. At first the ejected matter is a yellowish frothy fluid, subsequently it becomes a dark green, and finally almost black. Retching and vomiting after the anæsthetic may continue for twenty-four hours, or even longer. It does not necessarily indicate peritonitis, even if it persists for several days. Similarly, as already mentioned, tympanites may be present and yet not be associated with peritonitis. Nor does the temperature give any characteristic indication, for I have seen many cases in which it has remained low throughout. But should there be a persistent acceleration of pulse, accompanied by vomiting and abdominal distension, then danger must be apprehended. The patient, moreover, has a jaundiced and haggard expression, the mental condition is depressed, and the tongue is red and dry, though sometimes it remains moist. No flatus is passed *per rectum*.

When peritonitis has been recognised, the question of treatment at once arises, and here I may say at once, if the peritonitis is general active treatment is of little avail. Some operators still think that free purgation is of use and that it may prevent peritonitis; there is no proof whatever that such is the case. Can any good be gained by re-opening the wound and flushing out the peritoneal cavity? My experience is that the proceeding is perfectly useless. I have never seen the least benefit from the attempt. At best only the most superficial coils of intestine close to the opening can be reached. The patient seldom survives the operation more than a few hours. The *post-mortem* examination reveals the impossibility and inutility of the whole proceeding. Pus is found

covering the whole peritoneal surface and extending into every recess and corner.

Intestinal Obstruction is a rare event, but it is well for the operator to bear it in mind. It may occur at any time subsequent to an abdominal operation, either by the intestine becoming adherent to the parietal incision or other raw surface, or by becoming entangled in the omentum. I have certainly seen one case which terminated fatally a month after operation, the condition not having been recognised. When intestinal obstruction occurs shortly after the operation, is it liable to be mistaken for peritonitis?

THE SERUM DIAGNOSIS OF TYPHOID.[1]

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The correct diagnosis of enteric fever is a matter of such supreme importance that any fresh method offering assistance in arriving at it is sure of a hearty welcome from the medical profession. In the past we have been dependent, in forming our opinions, on a combination of symptoms only one of which is constantly present. This symptom, fever, varies, however, in severity, in duration, and sometimes even in type, and is also a symptom in a large number of other diseases. All the other symptoms are infinitely more variable and indefinite. Hence a diagnosis can seldom be arrived at until the patient has been ill for at least a week; and sometimes even after the fever has run its course a doubt still remains as to the nature of the illness. Attempts have frequently been made to solve this problem by employing bacteriological methods of research. It seems to be certain that the bacillus described by Eberth and Gaffky is present in the mesenteric glands and the spleen of all cases of enteric fever, and in the stools in all cases after the ulceration of Pyer's patches. The separation, however, of this bacillus

[1] This paper is based upon work done in the Bacteriological Laboratory of the Westminster Hospital.

from the other organisms present in the fæces requires a long and elaborate piece of work. Aspiration of the spleen, the most certain method of obtaining the bacillus from patients suffering with typhoid, is an operation which would hardly commend itself to English physicians, although no harm seems to have followed its employment; and the urine, the bacteriological examination of which has been much commended as a means of early diagnosis, has been proved by Dr. Horton Smith, in a paper read before the Royal Medical and Chirurgical Society last February, to only contain the bacillus later on in the disease, and then only in exceptionally severe cases. The bacillus, too, even when isolated, requires a prolonged and tedious research to prove its identity with Eberth's bacillus. A recent paper by two French observers[1] has raised fresh objections to methods of this kind, since they claim to have isolated bacilli indistinguishable from Eberth's bacillus by all the tests at present known—from the soil, from water, and from the fæces of people who were not suffering, and had not suffered, from typhoid. If their results be confirmed, bacteriological examination of the fæces, at any rate, will supply us with no information of assistance for the diagnosis of typhoid.

During the last twelve months the problem has been attacked from another point of view, and with much more hopeful results. As early as 1889 it had been noticed that when emulsions of motile pathogenic organisms were mixed with serum obtained from animals that had been artificially rendered immune to the particular disease associated with each sort of organism, the bacilli were rendered motionless and collected into clumps.[2] This phenomenon was shown to be specific by Gruber and Durham,[3] the bacilli being only affected by the serum of animals immune from their particular disease. Gruber and Durham applied this reaction to distinguishing motile bacilli from one another by observing whether turbid emulsions of the bacilli cleared up, when serum from an animal rendered immune from a particular disease was added, and by observing the formation of clumps under the microscope. Pfeiffer found that if a virulent culture of the bacilli of typhoid or cholera be injected into the peritoneal cavity of guinea pigs, together with serum from guinea pigs that had been artificially rendered immune

from those diseases, the bacilli, instead of growing, collect into clumps, become granular, and are ultimately absorbed. This action was found also to be specific; the serum of animals rendered immune from typhoid only acting on the typhoid bacilli, that of those immune from cholera only on the cholera bacilli. If these bacilli be injected into the peritoneal cavity of a guinea pig with the serum from a guinea pig that has not been rendered immune from their particular disease, or without any serum, they grow rapidly and soon cause the death of the animal. Pfeiffer also showed that serum from a patient convalescent from typhoid acted in the same way, though not so strongly as serum from an immune guinea pig. It was next discovered that the reaction *in situ* described by Gruber and Durham took place not only when serum from patients convalescent from typhoid was used, but also with the employment of serum from patients during the course of the fever; and the method was independently applied for the diagnosis of typhoid, while the fever was still high by Grünbaum[5] and Widal.[6] The latter, who has done a very large amount of work on the subject, described three ways of applying the method. In the first of these a few drops of serum from the patient were added to a turbid culture of typhoid bacilli in beef broth, and it was observed a few hours later whether a precipitation had taken place rendering the fluid clear. In the second way a few drops of serum were added to a tube of beef broth, and then this was infected with Eberth's bacillus and incubated at 37° C. for twenty-four hours; if the serum was from a case of typhoid, a precipitate collected at the bottom of the tube leaving the beef broth clear. Under the microscope the precipitate in this, as well as in the first method, was found to consist of heaps of microbes. Both these methods require vigorous precautions to prevent contamination of the cultures, and also necessitate the employment of relatively large amounts of blood.

Wright and Smith,[7] by employing capillary tubes instead of test tubes have, however, shown that they can be carried out with only a drop or two of blood. Widal's third method simply consists in taking a drop of blood (or the serum from such a drop), which can easily be obtained by pricking the finger or the ear of the patient and mixing this with from five to ten drops of a young beef-broth culture of Eberth's

bacillus, and then examining a hanging drop from this under the microscope. If the blood, &c., from a patient who is not suffering from typhoid, the bacilli are seen to be quite separate from one another, and are very active, darting right across the field; while, if the blood be from a case of typhoid, they become motionless and collect together into balls. The reaction may take place in a few minutes, or may require several hours. This last method is the one now usually employed, since it seems to be just as accurate as the others, requires much less time and trouble, and necessitates only a very slight disturbance of the patient. Blood can easily be sent to a bacteriological laboratory in a glass pipette, or dried, as recommended by Dr. Wyatt Johnston[8] on a piece of glazed note-paper, which can be sterilised by heating over a flame or in front of a fire. I have tried both these ways of forwarding specimens of blood, and have obtained successful results with both, but I prefer fluid blood in glass pipettes. During the last nine months, since Widal published his first paper, a very large number of examinations have been made by this method, and most experimenters have expressed very favourable opinions of it. The earliest reactions recorded have been on the second day of the disease, when partial reactions have been seen by Wyatt Johnston[8] and Fraenkel[9]; on the fifth day the reaction is frequently marked, and is usually very marked by the seventh day. Indeed, some observers state that if the reaction be not present by the seventh day, the case is not one of typhoid. In some cases the reaction may still be obtained for several years after convalescence, while in others, as Widal and others have pointed out, and as I can confirm from my own observations, the reaction becomes less marked early in convalescence, and may soon disappear. In cases where the reaction is marked, it can be obtained even when the proportion of blood to beef-broth is 1 in 20, 1 in 40, or even 1 in 200. Some observers, including Durham,[10] have seen cases which, clinically, were marked cases of enteric fever, where throughout the course of the fever no reaction could be obtained, Durham using a dilution of 1 in 20. Widal, too, says that in some cases a dilution of only 1 in 5 is necessary for obtaining the reaction.

In my own experiments, which were carried out in the Bacteriological Laboratory of the Westminster Hospital

Medical School, the blood was mainly obtained by the kind permission of my colleagues in charge of the wards, Dr. Allchin, Dr. Donkin and Dr. De Havilland Hall, from patients in the Westminster Hospital, but in some cases blood was sent to me by medical acquaintances outside, and from the Shadwell Hospital for children. The method used was Widal's rapid method, one drop of blood being mixed with ten drops of a beef broth culture of typhoid bacilli, which had been incubated for twenty-four hours at 37°C. The typhoid culture had been in the laboratory for about three years, but gave all the distinctive reactions of a culture of Eberth's bacillus. From this stock-culture secondary cultures on nutrient agar were made about once a month, and from these the beef-broth was infected. Samples of blood from 164 cases were examined, repeated samples being taken from cases that gave the reaction. The results obtained are given in the following table, the relation of serum to beef broth being always one to ten.

Total number of cases examined, 164.

(*a*) Clinical cases of typhoid, 21.

{ Typhoid with fever, 9 cases.
{ Typhoid convalescent when first examined, 12 cases.

Number of cases of typhoid where reaction was obtained, 21.

Reaction obtained during primary fever in 8 cases.

Reaction obtained for first time during relapse in 1 case.

Earliest reaction obtained on the 6th day.

Latest reaction obtained on the 104th day.

No case examined later than the 104th day.

(*b*) Cases not suffering from typhoid, 143.

Reaction obtained in 2 cases.

No reaction obtained in 141 cases.

The twenty-one cases of typhoid were either obviously cases of typhoid when first examined, or were proved by their subsequent clinical course to be cases of typhoid. In every one of these a positive reaction was obtained at some time or other of the course of the disease. As a rule it was found when the case was first examined, which was in most cases later than the seventh day of the disease. Twice it was obtained as early as the sixth day, while in one case, and that not a very mild one, the reaction was not marked until

the third week. In a particularly interesting case under Dr. de Havilland Hall, where the patient entered the hospital with continued fever and symptoms of laryngeal catarrh, the reaction did not take place during the fever nor during the subsequent apyrexia. Dr. Hall[11] came to the conclusion in spite of this that the patient was suffering from laryngo-typhoid, and on the seventh day of his convalescence a relapse took place, in which the fever ran a typical course, and there were typical spots, typical stools and an enlarged spleen. On the fourth day of this relapse a marked reaction was obtained. A somewhat similar case has recently been reported in Paris by Thoniot and Cavasse;[12] a mild case of typhoid, lasting twelve days, had subsequently two typical relapses; no reaction was obtained until the patient was suffering from the first relapse, and the reaction only became marked during the second relapse, the blood being examined repeatedly.

These cases confirm very strongly the contention of Durham and others that it is possible for a patient to suffer from a mild attack of typhoid, without Widal's reaction being obtained with his blood, at any rate when the usual dilutions are used. Very different was the result obtained in another case, also under Dr. Hall; a young girl, while in the hospital suffering from chorea, was attacked with fever, lasting eight days without any other marked symptoms except epistaxis; on the sixth day of this attack a typical reaction was obtained; after seven days' apyrexia a relapse with typical symptoms of typhoid took place, followed later by thrombosis of both the femoral veins, after it was first obtained the reaction was present throughout, although it became decidedly less during the apyrexial period, increased during the relapse and diminished again during her convalescence. In another case also a distinct diminution of the intensity of the reaction was noticed on the fiftieth day of the disease, the twentieth day of convalescence. A patient with evident signs of phthisis was admitted under Dr. Donkin with fever, this fever lasted for three weeks, and during the second week of the fever a number of rose spots appeared on the trunk, and the patient had diarrhœa with pea-soup-like motions; the presence of Widal's reaction rendered it practically certain that the fever here was due to an attack of typhoid and not to an extension

of the tuberculosis of lungs. In a case of my own the reaction confirmed my opinion that an illness, which the patient had been suffering from for three weeks, and which was chiefly characterised by malaise and some fever, had been typhoid; the temperature became normal the day after I first saw the patient, and when she was examined there were no physical signs of disease except the fever to be found. In a few cases where no reaction was obtained there was for a time suspicion that the patients were suffering from typhoid; the subsequent clinical course of all these cases, however, was not that of typhoid, and the most suspicious case of all proved *post-mortem* to be one of tuberculosis. Several cases of phthisis or other tuberculous affections were examined, in none of which was the reaction obtained. An examination was also made in a number of cases of pneumonia, broncho-pneumonia, pleurisy, acute rheumatism, &c., while the patients were still feverish and during convalescence, but in none was the reaction present. Dr. Delépine[13] obtained negative results invariably on examining the blood from cases of scarlet fever, mumps, erysipelas, puerperal fever, &c. In two cases, however, I obtained a positive reaction where the patients were not suffering and had not suffered from typhoid. One was a case of cirrhosis of the liver, the other of biliary colic, and in both there was slight jaundice. Unfortunately, I missed the opportunity of trying the reaction in these instances with greater dilutions than 1 in 10.

Grünbaum[14] has pointed out that a positive result is frequently obtained in cases of jaundice when the serum has not been sufficiently diluted. In two cases, however, of intense jaundice I obtained negative results. With the blood of a patient suffering from hæmorrhagic pleural effusion, the reaction was positive when the serum was only diluted 1 to 5, but negative when 1 to 10. A few other instances of the reaction occurring with dilutions of 1 in 10 have been reported, one for instance by Ferraud[15] in a case of septicæmia, caused by streptococci and proved *post-mortem* not to be typhoid, and another by Jez[16] in a case of tuberculous meningitis. The serum from cases of that contagious disease of parrots, psittacosis, gives a marked reaction with typhoid bacilli, and Widal[17] found that very considerable dilutions

of serum from typhoid patients were required to distinguish by this reaction between typhoid bacilli and the psittacosis bacilli. Similarly, it is only with dilute serums that one can distinguish by the reaction between typhoid bacilli and coli communis bacilli. However, the exceptions, where a reaction occurs with blood from patients not suffering from typhoid, are very rare when a dilution of 1 in 10 is employed, the errors in my cases being only 1·4 per cent.

The method, although it must seem very easy to employ, is not suitable for bedside work, and requires for its proper application practice in bacteriological research, and a properly fitted bacteriological laboratory. It is, however, as I have before pointed out, very easy for any one to collect suitable samples of blood, and to send them to a bacteriological laboratory, where the rest of the process can be carried out. To obtain trustworthy results it is, of course, necessary to observe certain precautions. First of all the culture of the typhoid bacillus used must be pure, and care must be taken to keep it from contamination. The subcultures in beef-broth must be young (24 to 48 hours old), when the bacilli will be found to be separate from one another and actively motile. Older cultures are liable to contain clumps, and the bacilli in them more sluggish. It is also essential to examine the beef-broth culture before it is employed, to see that it does not already contain clumps, and that the bacilli move actively. It is usually easy after practice to distinguish such small casual clumps among actively moving bacilli from the numerous large clumps with motionless bacilli formed after addition of serum from a case of typhoid. In certain cases, however, where the reaction is not marked, the clumps formed are not large, and some of the bacilli still retain their mobility. The reaction in most instances takes place almost at once, within half-an-hour of the addition of the serum; but where only a slight reaction is obtained this may not appear for several hours. Such slight reactions generally occur in the early days of the disease, and here the blood should of course be re-examined a few days later. In this connection it is interesting to observe that sometimes the bacilli, after losing their motility directly after the addition of the serum, regain it to some extent after an interval of twenty-four hours. Another important precaution, as has been especially pointed out by Grünbaum,[14]

is to dilute the serum sufficiently with the beef-broth culture used. Normal blood serum will cause bacilli to lose their motility and to form clumps when the proportion of serum in the mixture is as high as 1 to 1, and 1 to 2, or even 1 to 4, and in certain rare cases, especially of jaundice, clumping and loss of motility may occur where the proportion is 1 to 10, or even 1 to 16. With a proportion of 1 in 20, the reaction seems only to come off with blood from typhoid patients, and where the dilution used is greater than this, the occurrence of a positive reaction renders it more and more absolutely certain that the specimen of blood examined is from a case of typhoid. Hence in cases of doubt where the reaction has been obtained, a repetition should be made, using greater dilutions of the serum. The routine employment of these higher dilutions is open to the objection that certain cases of typhoid, giving only slight reactions with a dilution of 1 in 10, would give none with more dilute serum. I think, therefore, that the proportion recommended by Widal is the best for routine use, and using this proportion I consider that we have in Widal's reaction, spite of its being liable, as I have shown, to a few errors, a symptom of typhoid more constantly present than any other except the fever, and giving us more certain information than any other symptom at all.

The causes of this peculiar reaction are very little known. The substance or substances causing it appear to exist in the blood serum, and not to depend on the presence of white or red corpuscles. The agglutinative power of the blood is much greater than that of serum from a blister, or of that of the tears or of urine, or of milk, all of which have been found to possess this power in cases of typhoid. The serum does not lose its power until heated to above 70° C. (or even 75° C.), as Widal has shown with the milk of a goat that had been rendered immune from typhoid. The fresh serum of animals has been found to have a bactericidal action in micro-organisms; the substance causing this has been called alexine, and is supposed to be derived from the leucocytes.[18] The serum of animals which have been artificially rendered immune from the pathogenic action of certain bacilli (for instance, the diphtheria bacillus), contains a substance, an antitoxine, which is a physiological antidote to the chemical poison, the toxine, produced by those bacilli during their growth, although this

antitoxine has no prejudicial effect on the growth of the bacilli themselves. Further, as Pfeiffer[4] has shown, other quite different substances are also produced in the serum of animals that have been rendered immune from the action of the cholera or typhoid bacilli, so that if this serum be injected together with a culture of the bacilli into the peritoneal cavity of a fresh animal, the bacilli, instead of growing and killing the animal, collect into balls, become granular, and die. This action of the serum is specific, only affecting bacilli from the action of which the animal from which it has been obtained has been rendered immune. In vitro such a serum has also a specific action on the bacilli, causing them to lose their motility and to collect into clumps, but does not kill them. This action in vitro has been shown by Pfeiffer to be due to other substances quite distinct from those mentioned above, and he has called these substances "paralysins," while Gruber[8] names them "agglutinines." Grünbaum,[14] indeed, considers that the loss of motility and the clumping of the bacilli are caused by two different substances; certainly these two phenomena do not vary proportionately with one another. Another subject of controversy is as to whether the reaction is to be regarded as a phenomenon of infection or as one of immunity. Widal, arguing from the early appearance of the reaction in certain cases, and from the recurrence of relapses after the appearance of the reaction and while the reaction is still marked, regards it as due to the infection of the organism. Grünbaum,[19] on the other hand, points out that immunity is always a question of degree, that you can always infect even a highly immune animal by giving a large enough dose of the poison. Animals can be rendered immune from typhoid by the injection of dead typhoid bacilli, and their serum shows the agglutinative power within three days. This action of dead bacteria can hardly be regarded as a "phenomenon of infection." The second day of illness in enteric fever means at least the ninth day after infection; so the occurrence of the reaction on that day is not very surprising. The degree of immunity in animals, after the injection of dead bacteria into them, apparently varies with the agglutinative power of their serum, *i.e.*, with the degree of dilution in which it will act. Human beings, after typhoid, are not highly immune, since they are liable to relapses, and we find that the agglutinative

power of their serum is much less than that of the serum of artificially immunised animals; the reaction does not take place with human serum from a typhoid patient in greater dilution than 1 in 400, while with artificially immunised guinea pigs a reaction can be obtained with a dilution of 1 in 10,000. The serum, too, reacts much more markedly and in greater dilution with bacilli that have lost much of their virulence by being artificially cultivated for a long time.

Lately attempts have been made to vaccinate human beings against typhoid by injecting into them dead typhoid bacilli, by Pfeiffer,[20] and by Wright and Temple,[21] the degree of immunity conferred being estimated by the agglutinative power of their serum. We are hardly, however, yet in a position to properly appraise the value of this interesting extension of Pfeiffer's work with animals.

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[20] PFEIFFER, *Deut. Med. Wochenschrift*, Nov. 12, 1896.
[21] WRIGHT AND SEMPLE, *British Medical Journal*, Jan. 30, 1897.

SUBCUTANEOUS ALIMENTATION.—In a communication to the *Münchener Med. Woch.* (August 4), Fritz Voit reports some experiments with subcutaneous alimentation. Leube had before injected melted butter in the dog, made lean by restricted diet, and an exploratory laparotomy revealed that the butter had been laid up in the form of fat. This fat in states of the system with insufficient heat was completely used by the economy, thus sparing the albuminoids. Leube had no success, however, with sugar in large amounts, but Voit observing that animals and man did not react alike, injected grape sugar in the latter with success. Of a 10 per cent. solution used with due antiseptic precautions, he found that he could inject subcutaneously (in the thigh) ten, one hundred, or one thousand cubic centimetres without inconvenience. As much as sixty grammes of grape sugar could be injected without a trace of it being found in the urine subsequently. Lèvrose and galactose could be used as well as dextrose, but lactose and cane sugar reappeared almost entirely in the urine. Sugar could not be used for alimentary purposes by direct injection into the veins of animals, as it was excreted at once with the urine.

THE WEANING OF INFANTS.—Dr. Louis Fischer (*Pædiatrics*, July 15, 1896) says that when a child reaches the age of six months it is well to think of weaning. Gradual weaning is usually very successful. Begin by feeding from six to eight ounces once during twenty-four hours. Each succeeding month withdraw one breast feeding and substitute artificial feeding, so that by the ninth month the infant is weaned. Complete weaning should take place about the tenth month, unless it is midsummer or there exists some other special condition. For artificial feeding, Dr. Fischer recommends three ounces of cow's milk, and if the bowels are regular, three ounces of barley gruel, and about ten-fifteenths of a grain of ordinary table salt and half a lump of cane sugar. He says that if the increase in weight is not five or six ounces weekly, a careful chemical and microscopical examination of the breast milk should be made.

Report of Proceedings.

The Annual General Meeting—Friday, July 16, 1897.

W. Bruce Clarke, Esq., F.R.C.S., President, in the Chair.

The Annual Report, the Treasurer's Report and the Librarian's Report were read and approved.

The Office-bearers for the ensuing Session, as suggested by the Council, were unanimously elected (*vide* p. 290).

The President then delivered his valedictory address, which is published in full on p. 221.

The following votes of thanks were proposed, seconded and carried :—

To the President, proposed by Mr. Keetley, seconded by Dr. Potter.

To the Treasurer, proposed by Mr. McAdam Eccles, seconded by Dr. Lamb.

To the Auditors, proposed by Mr. Alderton, seconded by Dr. Des Vœux.

To the Secretaries, proposed by Dr. Alderson, seconded by Dr. Dobson.

To the Editor of the Journal, proposed by Mr. N. Wood, seconded by Dr. McCann.

To the Editorial Secretary, proposed by Mr. N. Wood, seconded by Mr. Alderton.

Report of Librarian.

At the beginning of the present year the number of bound volumes in our Library was about 500. Since then others have been added and many more offered; but the progress of the Library has been brought more or less to a standstill by the want of proper accommodation. With a view to getting more room and better lodging for the books as well as for the meetings of the Society, a Committee of Council was appointed. It made certain recommendations, and deputed the President and myself to interview the Chairman of the hospital with respect to them. I am sorry to say that as regards the Library no improvement or prospect of improvement has so far resulted from this interview. The present condition may be described as a deadlock.

(Signed) C. B. Keetley,
Hon. Librarian.

THE INSTITUTION OF THE CAVENDISH LECTURE AT THE WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

On the occasion of the delivery of the Cavendish Lecture by the late Dr. Andrew before the Society on June 7, 1889, Dr. Thudichum, in supporting a vote of thanks to the lecturer for his learned and eloquent address, referred to the historical circumstances which had caused the Society to institute the lecture as an annual function, and to signalise its aims and objects by connecting with it the name and memory of Henry Cavendish. He said that in the biographical account of John Playfair, most celebrated as the successful indicator of "The Huttonian Theory of the Earth," and renowned as Professor of Natural Philosophy in the University of Edinburgh, which was prefixed to the edition of his collected works printed in 1822, occurred an interesting extract from a journal, which he wrote while on a visit to the metropolis in the beginning of 1782, "That he might have an opportunity of seeing what is there most worthy of observation, and of conversing with those men whose names are known in the republic of letters." We thus obtain (continued the speaker) an invaluable record of some of the characteristic qualities of Henry Cavendish and some of his most noted contemporaries. Playfair first speaks of his intercourse with Dr. Maskelyne, the astronomer royal; with Dr. Horsley, "who talked very seriously of the notion of mind being united to all the parts of matter and being the cause of motion; of every atom having a soul," &c. He then speaks of "the illiberal, though learned," prelate Warburton, who held that the study of natural philosophy made men atheists and materialists. The learned Scotch professor visited Greenwich Observatory to greet the shades of Halley and Bradley; then the British Museum and saw Solander, who "is indeed a very pleasant man, has lived much in the world, both of literature and of fashion, and has conversed much both with the polite and the savage." Playfair thinks him "not profound in mineralogy, from his recommending Linnæus's 'History of Fossils,'" which thus appears to have been antiquated already at that period. "But one thing for which I admire him," continues Playfair, "is that he takes an interest in all the sciences, and is not of the number of those naturalists who, while they count the scales of a salmon, or inspect the wings of a butterfly, despise the labours of the moralist or the astronomer."

Playfair was "carried" by Dr. Solander to dine with the club of the Royal Society at the Crown and Anchor. . . . "but little pains was taken to make the company very agree-

able to a stranger." The club improved, however, very much on better acquaintance. The visitor was considered a man of some industry, and his "Dissertation on Impossible Quantities" seemed to have made some impression by its apparent depth.

At this club Playfair found Mr. Smeaton, the engineer, and M. Aubert, a private gentleman, foremost in astronomy. Of Smeaton we learn that he proved that in the collision of bodies there was a loss of mechanical power, but his contemporaries did not understand him at all; Cavendish particularly was opposed to his thesis. Smeaton was very embarrassed in his language, and Playfair puts his non-success in scientific argument to that account. Since we know that arrested motion is transformed into heat, we know that Smeaton was correct. We also learn that Smeaton was brought up as a mathematical instrument-maker, and became an engineer, without any liberal education. This self-teaching, even as concerns well-known matters, he exhibited best in his experiments on puzzolana, the volcanic ash, which with lime yields the hydraulic cement with which he built the once celebrated Eddystone lighthouse.

Playfair next describes the man whose name and achievements we commemorate by this annual lecture.

"Mr. Henry Cavendish is a member also of this meeting. He is of an awkward appearance, and has certainly not much the look of a man of rank. He speaks likewise with great difficulty and hesitation, and very seldom; but the gleams of genius break often through this unpromising exterior. He never speaks at all but that it is exceedingly to the purpose, and either brings some excellent information or draws some important conclusion. His knowledge is very extensive and very accurate; most of the members of the Royal Society seem to look up to him as to one possessed of talents confessedly superior; and indeed they have reason to do so, for Mr. Cavendish, so far as I could see, is the only one among them who joins together the knowledge of mathematics, chemistry and experimental philosophy."

Further on in his note Playfair says that "chemistry was the rage in London" in 1782. He was introduced to a chemical society which met once a fortnight at the Chapter Coffee House. There he met B. Vaughan; Whithurst, author of an "Inquiry into the Formation of the Earth"; Dr. Keir, Dr. Crawford and others. The conversation was purely chemical and turned on Bergmann's experiments on iron. At Vaughan's and his father's house, "who were both dissenters," he found all the chief men "of that interest" assembled: Dr. Price, Priestley, Kippis, Tours and others. Playfair

thinks that as an orthodox Scotchman he was looked upon "with contempt or abhorrence." Priestley's conversation had nothing in it very remarkable. At that time Priestley experimented with hydrogen on oxides, in the language of the time "inflammable air on calces," and believed he had shown that inflammable air was the same thing with phlogiston. Priestley is supposed to make theories as quickly as he abandons them, and on the whole "neither from his writings nor from his conversation is one much disposed to consider him as a person of first rate abilities."

It is on this background that Henry Cavendish is put before us in the terms mentioned. His experimental skill and power of thought were appreciated more fully at a later period. He was born at Nice in 1731, and died in 1810. Among many experimental achievements he repeated Maskelyne's experiments on the density of the earth, with lead balls nine inches in diameter, which came to $5\frac{4}{5}$ times that of water. Most of his papers were published in the *Philosophical Transactions* between 1766 and 1792. How he composed and decomposed water and carbonic acid is matter of history, and his theory of water is the very basis of all our chemical physiology, both of animals and plants.

Ocular Symptoms in Disseminated Sclerosis.—Kunn (*Arch. d'Ophtal.*, June, 1896) observed in Prof. Nothnagel's clinic twenty cases of disseminated sclerosis, six of which he made the basis of his paper. The three most common and marked symptoms were:—(1) Nystagmus or "intentional tremor or ataxia of the ocular muscles," occurring mainly in fixation or in extreme lateral contraction. (2) Dissociation of the muscles of the eyes, from a transient paralysis producing, in every case, an internal strabismus *without loss of power of rotation*. Its transient character and the apparent inconsistency—a paralysis with full individual function of muscle—is, Kunn claims, the peculiarity of the strabismus of ataxics. (3) The complaint of patients that they are no longer able to read clearly, that dark objects appear in the visual field, and that letters blur and become confused, and yet they retain full or nearly full acuity of vision. This symptom is ascribed to nystagmus of the ciliary muscle, since, under paralysis of the accommodation with atropine and the substitution of the accommodation with plus 5D., the glass being covered, excepting a small pupillary space, with an opaque substance, reading is accomplished without difficulty. These three characteristic symptoms are not permanent, but disappear and reappear after varying intervals.

The Mirror of Practice.

A CASE OF ACROMEGALY.

By James B. Ball, M.D., M.R.C.P.
Physician to the West London Hospital.

Mrs. M., aged 51, was admitted into the West London Hospital on June 14, 1897. She had noticed that for many years her face, hands and feet had been slowly enlarging. The following history of the case was obtained by the house-physician, Mr. Ellacombe. About twenty years ago her menstruation ceased, and has never reappeared since. From the same date her features began to alter. She thinks the lower part of her nose was the first to enlarge. Her hands, feet, and lower jaw began to enlarge about this period, and continued gradually to increase for many years. People who had known her previous to this period, and had not seen her for some years, did not recognise her. About seven years ago her wedding ring began to eat into the skin, owing to enlargement of the finger, and she had to have it cut, and another ring made for her. She used to wear six and a half gloves, but of late years she wears the largest she can get. For some years she has had to have her boots made to order for her, as she can find none to fit.

She was always healthy when young, and never had any ailment, except occasional bilious attacks. Her father died at 73 of a fit. Her mother died at 63 of rupture. She has three brothers all healthy. She has had six children, of whom one died at 13 of scarlet fever, and the rest are alive and healthy. She suckled all her children for about fifteen months, including the two last, who were born, one two years, and one six years after her menstruation had ceased. About eight years ago she began to suffer from prolapse of the womb. She underwent an operation for this, but about a year afterwards the prolapse returned, and she has worn a pessary ever since.

For the last four years she has been getting thinner. A few years ago she weighed 11 st.; her present weight is 9 st. 10 lbs. Her appetite has always been good. She does not suffer from thirst. She has suffered from headache in the mornings for the last few years; the pain is sometimes frontal, sometimes occipital. She often has pain in the lumbar region, but has not suffered from pain in the limbs at any time, as far as she remembers. She has not experienced any impairment in her sight, or any diminution in her sense

of smell, taste, or hearing. No change in her voice has been noticed.

The following notes were made of the present condition. The face is large and oval in shape. The forehead is high and receding, and appears narrow from side to side, in proportion to its height. The supra-orbital arches are thick and massive, and the outer part of the arch, separating the orbit from the temporal fossa, is especially strongly marked. The temporal fossa appears hollowed out, owing to the prominence of the orbital arch, the zygomatic arch, and the temporal ridge. The malar bones stand out large and prominent, the left more so than the right, causing a decided asymmetry of face. The nose is very large, the enlargement involving, not the nasal bones, but the cartilaginous and tegumentary framework. Thus, while the bridge of the nose does not appear unusually broad or prominent, the lower portion of the nose is very broad and prominent, the alæ nasi are very thick, and the tip or lobule of the nose is very large. The skin over the nose is thick and coarse, and the hair follicles very apparent. The lips are thick, and the lower lip is especially large and thick, and is somewhat everted. The lower jaw is large, the chin massive, and the lower alveolar arch broad and prominent. The lower teeth project somewhat in front of the line of the upper teeth when the jaws are closed. The tongue is large and broad. The ears, though large, are not strikingly so. The larynx, as felt in the front of the neck, is strikingly large. The thyroid body can be distinctly made out, but is not enlarged. The clavicles are markedly enlarged at the sternal and acromial ends. There is a very marked prominence at the junction of the manubrium and body of the sternum. The chest is flattened from side to side, the ribs, especially from the second to the fifth, bending very sharply forwards at their angles. The ribs, especially the upper ones, are enlarged. There is a marked posterior curve in the upper dorsal spine, and slight deviation of the line of the spinous processes to the right, in this region. The iliac crests and spines are strikingly thick and massive. The hands are broad, massive, and clumsy looking. The ball of the thumb is large and prominent. The fingers are broad and flattened antero-posteriorly, especially the index and middle fingers of each hand. There is a slight enlargement of each middle finger at the joint between the proximal and middle phalanx. The ring finger is not so uniformly broad as the others, and presents a marked nodosity at the same joint. The thumb is large and broad, especially the second phalanx. The nails are broad and present longitudinal striations, more plain in the forefingers than the others. The feet are large,

but not as strikingly so as the hands. The toes are large, broad, flattened, square-looking; the second phalanx of the great toe is especially large. The wrists are decidedly large, apparently from enlargement of the lower end of the radius, but the ankles are not markedly enlarged. The heart and lungs are normal. There is no retro-sternal dulness to be made out. Pulse 84, regular; tension higher than normal. The bowels are generally constipated. She suffers at times from hæmorrhoids, and often passes blood with the motions. She passes about three pints of urine on an average in the twenty-four hours; the specific gravity varies between 1020 and 1026. There is a faint trace of albumen, and a small amount of sugar, about 1·25 per cent. The skin is not dry, and she states that she perspires very freely as a rule. She sleeps badly, and has done so for some years; and, as already mentioned, she often has headache in the morning. She is not depressed in spirits or melancholic, although her aspect suggests depression. The patellar reflexes are normal. Mr. Percy Dunn examined the eyes and reported that the fundus was quite normal in each. Vision in both eyes $\frac{6}{12}$ + 1 D. = $\frac{6}{6}$ and cum + 3 J. 1 at 8 in.

Remarks.—This case is a typical example of acromegaly. The patient did not come to the hospital for treatment, but was first observed when bringing her boy for treatment in the throat department. Although fully aware that certain changes had taken place, from trouble she had had with her ring, gloves, and boots, and from her not being recognised by friends who had not seen her for some years, she was unaware that she was the subject of any special disease. The early disappearance of the menses is very characteristic of the onset of the disease in women, although it is to be noted that, in this case, it did not imply sterility. She had two children after her menses had ceased. Glycosuria has been not infrequently noticed in association with the disease. Although the disease has existed for twenty years, the patient enjoys fair health, though she has lost flesh somewhat in the last few years, and complains of feeling weaker than she used to. There is no evidence of enlargement or other disease of the thyroid, nor any dulness over the upper part of the sternum, indicating persistence of the thymus, conditions which have sometimes been noted. There is an absence of any marked ocular troubles, such as hemianopia, amblyopia, optic neuritis or atrophy, &c., which have been frequently reported in cases of acromegaly. The changes in the optic nerve, as well as intense headache and other cerebral symptoms, have been shown to be due, in many cases, to a tumour of the pituitary body. The frequency of disease of the

pituitary body has indeed suggested the administration of pituitary tabloids in this disease, but there is no real evidence that this, or any other treatment, has benefited the disease. This patient has not been put on any special treatment. The appearance of the patient and a skiagraph of one of her hands are shown on the plate accompanying these notes.

A CASE OF CHRONIC (MILD) TETANUS IN A CHILD; RECOVERY.

By Arthur Whitfield, M.D., M.R.C.P.
Assistant Physician, West London Hospital.

Ada M., aged 7 years, first attended my out-patient clinic on June 4, 1897, complaining of sore throat and inability to walk or stand.

History.—She has always been a delicate child, but was in her usual health until a fortnight ago, when she complained of a sore throat, which has been getting worse since. Five days ago she had a fit and since then has been unable to walk or stand properly. On close questioning it appeared that her head was drawn violently back in the attack, and her back arched. She bit her tongue badly during the fit.

Present Condition.—A pale, poorly nourished child, with anxious, fixed expression of countenance. Head rather strongly retracted. She was brought in by her mother, half carried, half walking, with her feet extended and inverted. On attempting to get a view of the throat it was found impossible to open the mouth wider than sufficient to admit the little finger. The throat was consequently not seen, but the tongue was found to have a large ulcer at the frænum, and to be covered all round with whitish sores corresponding to indentations of the teeth. The glands below the jaw were much enlarged and tender. On account of the great pain complained of at the back of the throat and neck, I consulted my colleague, Mr. Bidwell, who examined the vertebræ but found no evidence of spinal caries. In attempting to obtain a better view of the throat, Mr. Bidwell inserted his finger into the mouth, whereupon the jaws closed with such force as to loosen a tooth against his finger. On examining the abdomen it was found somewhat retracted, and the legs were rather rigid, but there was no paralysis. The temperature was normal and no signs of disease were found in any other organs. As the mother said she had had but one fit, and her condition

was not noticeably deteriorating, it was decided to watch the case, and she was told to appear on the following Tuesday (8th). At this time the diagnosis of tetanus was considered but not regarded as certain. On Monday (7th), however, she got rapidly worse and was admitted into the hospital under Dr. Drewitt, to whose courtesy I am indebted for permission to publish these notes. On admission the condition was much the same as I observed on the Friday (4th), with the exception of greatly increased rigidity of the muscles round the neck and occasional spasmodic contraction of all the muscles of the body. The temperature on admission was 99° F. and during her stay in hospital kept about the normal line, generally a little below. She was put upon a milk diet until the physician should come and see her. When Dr. Drewitt came he decided the case was one of very mild tetanus, and as there was some difficulty in obtaining the antitoxin, it was decided to treat her merely by rest and quiet, with an antiseptic wash for the mouth. She was accordingly given potass. chlorat. gr. j. every six hours.

On the 9th, she was in the same condition with occasional mild attacks of opisthotonos, of which she had two in the night with considerable dyspnœa. Ordered pulv. glycyrrhizæ co. ʒj. in the morning, for constipation.

On the 10th, the patient was anæsthetised with chloroform to examine the throat, but although the drug was pushed to the limits of safety, and all other muscles were relaxed, the jaw could not be opened any more than before. This gave rise to doubts whether there might not be some inflammatory mischief at the articulation. She was now given a mixture containing tinct. cannabis ind. ♏ v. and pot. brom. gr. v. every four hours, also hyd. cum cret. gr. j. three times a day, the constipation being very marked. After this no further treatment was given until convalescence, except drugs directed against the obstinate constipation.

June 12.—She can open her mouth a trifle wider to-day and without pain, but on trying to protrude the tongue, or if one tries to press the tongue down she has great pain. She had one attack of spasm last night, but not so severe. Swallows easily and can take semi-solid food. The tongue is slightly cleaner, and the child says she feels quite well, but the abdomen is still very rigid.

June 17.—She is now greatly improved, and can open the mouth to nearly the full extent. Tongue much cleaner. The edges have been bitten nearly the whole way round and nearly through in one place on the right side. Muscles nearly all relaxed now, but still enlarged glands under jaw.

June 20.—Abdomen still rigid, and back somewhat so. Cannot protrude tongue far; otherwise well.

June 27.—Progressing steadily; nearly all rigidity gone. Protrusion of tongue normal. Glands under jaw nearly normal in size. Feels well, and eats and sleeps well.

July 7.—Discharged; to come up as out-patient.

July 13.—Came up to-day as out-patient; seems only a little weak now. Taking cod liver oil and syr. ferri. phosph. co.

Remarks.—Tetanus is so rare a disease, with modern antiseptics, that I have thought the above case of sufficient interest to publish. The chief points of special interest are, the absence of cutaneous lesion which was carefully sought for but never found, the fact of the disease coming on apparently as a sequel to a sore throat, and the persistence of the spasm of the jaw muscles during deep narcosis. As regards the first point there is nothing to be said, but in searching for the situations of the lesion of entrance in cases of tetanus, I find that lesions of the gums have produced the disease, and have been attributed to chewing straw or accidental scratching in swallowing grain. As the incubation period of tetanus in man is known to vary from one to twenty-two days, it is quite possible that the sore throat was the original site of entrance through scratching and infection from food. I have also found a case reported where a tetanic spasm in one thigh remained under the deepest chloroform anæsthesia, but this is said to be extremely rare. The constipation which was so obstinate in this case is an almost invariable occurrence in the disease. As regards treatment, although the antitoxin is the only form which is of any direct use, still this itself is by no means satisfactory. In the first place it should be used very early, and even if immediately after the first symptoms the poison has been accumulating for some time in the body. Secondly, the antitoxin is purely a measure against the products of the bacillus and has no action on the bacillus itself, so that the symptoms of the disease have been relieved by it, but have recurred and caused death on stopping the injections. Thirdly, this case was so mild and seen so late that the ultimate prognosis was favourable from the date of admission without resorting to the antitoxin, and this prognosis was justified by the course of events.

THE PROPHYLAXIS OF SCARLATINAL NEPHRITIS.—In more than a hundred cases of scarlatina seen in the course of six years, in which the patients were for three weeks kept upon milk diet, Ziegler (*La Semaine Méd.*) did not once meet with nephritis as a complication.

A CASE OF PROLONGED SUPPRESSION OF URINE.

By H. Percy Potter, M.D., F.R.C.S.
Medical Superintendent Kensington Infirmary.

The cause of suppression is in most instances diagnosed without difficulty, but in this case the patient recovered without a determination on our part of the nature of the disease. In connection with acute tubal nephritis, temporary suppression is not an uncommon symptom. It is also the mechanical accompaniment to certain forms of diseased pelvic organs, leading to obstruction of the orifices of the ureters. By effecting free action of the skin and bowels, the blood was relieved of excretory products and the symptoms gradually disappeared.

The patient was a man aged 24, who had been for some time a heavy drinker. He was sent to the Infirmary for "collapse" on July 19 last. On examination the following symptoms were present: drowsiness, and a disinclination to answer questions, relapsing into partial unconsciousness; duskiness of countenance, with capillary injection of face; hurried and deep breathing; arterial tension with marked pulsation of carotids; slight anasarca of the lower extremities; temperature 97° F. falling to 95·8° F. on the 20th; wandering delirium at night. There was no vomiting; no urinous odour of the breath or skin; physical signs of the chest *nil;* pupils not contracted; no retinal changes. The bladder was quite empty, and so far as I could ascertain from the friends, "urine had not been passed lately," but the history of the onset of symptoms was untrustworthy.

Croton oil and a hot air bath were given on admission, also pilocarpine, gr $\frac{1}{8}$, subcutaneously every six hours. Half a drachm of compound jalap powder was prescribed every morning. The bowels and skin acted freely and the delirium disappeared; the patient became very thirsty and took freely of milk and soda-water.

No urine was passed until July 23—142½ hours from the time of admission—when about ten ounces were voided in bed; enough was, however, saved for examination, which proved the urine to be clear, to have a sp. gr. 1010, acid reaction, no albumen, no casts. Subsequent specimens gave similar results. The pilocarpine was discontinued on the 25th; the patient became quite sensible; torpor disappeared, and the kidneys resumed their functions. He made a complete recovery by August 3.

We have said that the diagnosis of this case was not arrived at. Most probably the case was not one of obstructive sup-

pression, for there was no evidence of constricted or blocked ureters. The absence of previous nephritic colic and crystals in the urine pointed to the improbability of stone.

The fact that no albumen nor blood were passed was interesting to those who watched the patient, but added obscurity to the case, and definite uræmic symptoms were at no time marked. For these reasons it could not be said with certainty that this was an instance of acute Bright's disease. But if such a condition as transient renal congestion exist, this case may possibly have yielded an example. I have thought that the above notes—although imperfectly detailed—may not be unworthy of record.

Reviews and Notices of Books.

BALL ON DISEASES OF THE NOSE AND PHARYNX.[1]

THAT a third edition of this book should have been called for in the short period of three years proves not only that it has filled a hiatus in the literature of the special subject with which it deals, but also that it has established for itself a popularity which is somewhat unusual in regard to books of its kind. The present edition contains many important additions and improvements, the result of which has been to place the work upon that footing of up-to-dateness which at once attracts the attention of the reader. For example, the chapter on diseases of the accessory sinuses has been almost entirely re-written, and contains an account of the recent advances in the diagnosis and treatment of those affections. For the most part the general plan of the work has been adhered to. The opening chapters, as before, give a clear and concise account of the anatomy of the parts dealt with; then follow a description of the physiology of the same and the facts relating to the manipulative methods required in the diagnosis and treatment of diseases of the regions concerned. Part II. contains a full account of the etiology, diagnosis, and treatment of the diseases of the nose, naso-pharynx, and accessory sinuses; while in Part III. is discussed the diseases of the pharynx. The book closes with a list of the chief formulæ, useful in the treatment of diseases of the nose and

[1] "A Handbook of Diseases of the Nose and Pharynx," by James B. Ball, M.D.(Lond.), Physician-in-charge to the Department for Diseases of the Throat and Nose, West London Hospital. Third edition, with fifty-four illustrations. London: Baillière, Tindall & Cox, 1897.

pharynx, an addition which, we think, materially augments the value of the work. For the rest we may add that this useful compilation has been well done; it is pleasantly written, is thoroughly practical, and contains no extraneous matter which would detract from its value as the handbook for busy practitioners desirous of gaining information upon the special subject with which it deals. The illustrations, to the number of fifty-four, interspersed in the text, have been judiciously selected, and carefully reproduced. Lastly, a word of praise is due to the publishers for the attractive form in which the volume has been issued.

LEWIS ON SPINAL CURVATURE.[1]

THIS little treatise on spinal curvature is written by a general practitioner for general practitioners, and contains much useful information about the etiology and treatment of the disease. It is illustrated by numerous very excellent illustrations, which have, in most part, been reproduced from original photographs, and the text is printed in large clear type.

The etiology and pathology of scoliosis is fully discussed, and under the head of diagnosis very good directions are given for the thorough examination of suspected cases, in which the importance of completely uncovering the patient as far as the great trochanters is insisted upon. A permanent record of the result of the examination should be made, either by marking a diagram, or better, by taking a photograph. This should be repeated every month and the diagrams or photographs compared.

In the chapters on treatment he fully reviews the various methods recommended by Barwell, Noble Smith, and Brodhurst, and describes the apparatus recommended by these writers. The mechanical appliance which the author recommends consists of a vertical bolster, which is fixed to the back of a chair on the side of the raised shoulder; when the patient leans back against the bolster she forces the shoulder, on that side, forwards.

He is strongly in favour of muscular treatment in scoliosis, and after referring fully to Dr. Roth's methods, he gives his experience of the use of Dowd's machine, which he advocates under skilled superintendence.

The book concludes with a chapter entitled, "A System of Medical Exercises," including those for the muscular treat-

[1] "The Relief and Cure of Spinal Curvature," by Dr. Percy Lewis. London: J. Bale, Sons & Danielsson, Limited, 1897.

ment of most deformities. This last chapter is most interesting and useful, and is well worth studying by those who are consulted about the slighter deformities of growing children.

MRS. HEWER ON THE MANAGEMENT OF BABIES.[1]

THIS little volume, which is intended for mothers and nurses, contains much valuable information, and will prove very useful to those who have the charge of young babies. While praising the greater part of the book, there are however one or two points of which we disapprove. Thus, before the chapter dealing with the preparation of a baby's outfit (which is excellent, and is evidently intended to be read by a mother before her confinement), we find a chapter devoted to the chief malformation of baby! Not very cheerful reading for a lady expecting her first infant. We would recommend that this chapter, which is useless to mothers, be omitted altogether, or the part dealing with the care of premature infants be transferred to the appendix. We are also surprised to read that the whole book has been revised by a London physician, since, although agreeing fully with the directions for feeding infants under one year, we cannot altogether accept the diet recommended after this age. Thus, we are recommended to give potatoes to children between 12 and 18 months of age, and are told that bread and butter should not be given before the age of 2 years. This is rather curious, for most physicians, experienced in children's ailments, would exactly reverse these instructions.

A chapter is devoted to the weighing and measuring of the baby, and others to accidents and illnesses of infancy. We are glad to see that in these last chapters mothers are recommended not to attempt to dose their children, except in trivial cases, without consulting a doctor.

TWENTIETH CENTURY PRACTICE OF MEDICINE.

WE would draw the attention of our readers to this work, which embodies the writings of specialists on both sides of the Atlantic, and which must become the most complete standard work of medicine. It is issued in twenty volumes, of which nine have already appeared. Full particulars are given in the advertisement inserted in the current number of the JOURNAL.

[1] "Our Baby," by Mrs. Langton Hewer; Fifth edition. Bristol: J. Wright & Co., 1897.

POST-GRADUATE TUITION IN LONDON.

[No Report for the current Session has been received.—Ed.]

Miscellaneous Extracts.

BRONCHIAL ASTHMA OCCURRING ONLY DURING MENSTRUATION.—The so-called asthma-uterinum is of rare occurrence, and its existence has been disputed by some. Katz reports a case in which the sputum possessed characteristic features of asthma, namely, Leyden's crystals, spirals, and sago-like pellets. The attacks of asthma and this characteristic sputum were present only during the menstrual period. The patient, aged 32 years, was in every other respect healthy. Nothing in her family or personal history explained the occurrence of these asthmatic attacks, which had existed about a year.—*Deutsche Med. Wochenschrift*, Dec. 10, 1896.

WHAT CASES OF OBESITY ARE SUITABLE FOR THYROID TREATMENT?—According to a writer in the *Gazette Hebdomadaire*, it is desirable to distinguish two classes of fat people. Those who are young, vigorous and plethoric, and who are good livers, receive little or no benefit from thyroid treatment. Such cases are benefited by a dietetic regimen. On the other hand, fat persons that are pale, soft and flabby, and inclined to œdema, receive benefit from the administration of the thyroid gland. They lose weight rapidly, oxidation is increased, and nutrition improved. This "torpid" obesity, which has some points of analogy with this œdema, is seen most frequently in women, while "florid" obesity occurs usually in men.

CAUSES AND TREATMENT OF ABORTION AND PREMATURE LABOUR. — Dr. Romheld (*Centralblatt fur Gynäkologie*) has studied 225 cases with reference to the causes of these conditions, and has arrived at the following conclusions: Syphilis is the most important cause and accounts for 27 per cent. of the cases; retroflexion of the uterus is accountable for 18 per cent.; chronic metritis and endometritis, 10 to 15 per cent.; uterine fibroids, 4·7 per cent.: abnormal conditions of the placenta, 4 per cent.; anteflexions of the uterus, 3·5 per cent.;

molar pregnancy, 1 per cent.; Bright's disease and lateral deviations of the uterus, 5 per cent. Constipation and anæmia are predisposing causes. Heredity does not appear to have much influence. The treatment is essentially prophylactic.

CONSTIPATION IN THE INSANE.—Alessi finds that mental troubles are aggravated when there is constipation and improved when the functions are regular. He also finds that in the melancholic forms of insanity, the intestinal atony preceded the outbreak of the insanity, while in violent mania it follows and seems to be produced by it, as there is evidently some connection between the action of the intestines and the degree of excitability of the special cerebral nerve centres. He concludes his interesting study of ninety cases in the *Gaz. degli Osp. e dell Clin.*, of March 28, with an account of a woman brought to the clinic in violent mania, which had developed suddenly that day. Inquiry of her mother elicited the fact that she had not had an evacuation for fifteen days, and the administration of 80 centigrams of calomel and 60 of scammony restored her promptly to sanity, as the intoxication had not lasted long enough to impair the integrity of the nerve cells.

CRANIECTOMY.—At the Paris Academy of Medicine Dr. Bourneville read a paper upon the above subject, the following of which is a summary: The examination of 350 crania collected in the Bicetre Hospital proves that, in idiotic and backward children, premature synostosis of the sutures does not generally exist. Inasmuch as the exact state of the sutures and the thickness of the cranium cannot be determined with any degree of accuracy in the living, it must follow that craniectomy must be done without exact data, and frequently upon crania which are perfectly able to afford the brain all the space that it needs. The examination of these crania shows, also, that craniectomy is not able to allow the brain much space of expansion. These facts justify the statement of anthropologists who assert "that the brain makes the cranium, and moulds it upon itself." Besides this the encephalic lesions, to which are due the greater number of the forms of idiocy, are deep, varied, and extensive, hence not susceptible of being modified by craniectomy. Most of the surgeons who have practised this operation agree upon the fact that in most instances their operative measures have been followed by slight or doubtful results, or by no improvement whatever; that serious accidents (paralysis, convulsions,

&c.) and that even death (13 times in 85 operations collected by the author) have resulted from it.—*Semaine Medicale.*

HOT-AIR TREATMENT OF ARTHRITIS. — The Talleman-Sheffield treatment of rheumatoid arthritis by means of hot air cylinders seems to be borne out by clinical experience, if we may judge by the reports of cases. The method consists in the local application of hot air to the parts affected. The apparatus by which this is accomplished consists of a copper cylinder, under which several gas jets are kept burning. Into this cylinder the limb is inserted and the ends are closed. Stop-cocks are arranged to let out moisture exuding from the skin, and the temperature is raised to 250 to 260 degrees. Precautions are taken to prevent the limb from coming in contact with the hot metal, and the application is continued for fully forty minutes. In most cases one application is sufficient, and the London hospital reports include the most chronic ones as absolutely cured by this means, even old cases of arthritis deformans. The affected limb is placed in the cylinder at a temperature of 150 degrees, and the heat is gradually increased to 240 degrees. During the treatment the pulse and temperature increase, but soon return to normal afterward.—*N. Y. Med. Times.*

MUSCULAR WRYNECK.—Dr. Kader (*Beitrage z. klin. Chir.*, vol. xvii., p. 207), having had an opportunity of studying thirty-four cases of wryneck, makes the following report of his investigations. In twenty-one of these cases the sterno-mastoid muscle was removed and microscopically examined. (1) In muscular wryneck there exists an interstitial fibrous myositis of the sterno-mastoid muscle. (2) This myositis consists in excessive growth of the connective tissue of the muscle and degeneration of the muscular parenchyma, its place being taken by newly-formed connective tissue, so that not only is the stroma thickened, but large patches are found which are partially or wholly connective tissue. (3) The myositis may affect the whole muscle or only a part of it. (4) The myositis has a chronic, progressive course, although its onset is marked by a more acute character. (5) The transformation of the newly formed granulation tissue into old cicatricial tissue produces the contraction, atrophy and rigidity of the sterno-mastoid. (6) Other muscles besides the sterno-mastoid may be affected; if so, the same process takes place in them. (7) The alterations sometimes observed in the nerves are secondary to those of the muscles, and are to be looked upon as caused by the extension to the nerves of the inflammation going on in the muscle.

PROPHYLAXIS OF THE PUERPERIUM.—Dr. Puls (*Annals of Gynæcology and Pædiatrics*, January) concludes: (1) Puerperal septicæmia is the result of contact infection. (2) Subjective antisepsis prevents infection. (3) Objective antisepsis should be practised only in cases of operative interference, but the prophylactic vaginal douche is not a safeguard against infection; the vaginal surfaces must be cleansed similarly as before a gynæcological operation. (4) The secundines must be delivered *in toto*, since the health of the lying-in depends upon a complete evacuation of the uterine cavity, and a further source of infection is wanting in the absence of placental or membranous remnants. (5) A normal lying-in period is unnecessarily tampered with by irrigating the genital tract. (6) Obstetric nurses ought never to nurse contagious diseases.

PNEUMONIA IN CHILDREN.—Dr. Griffith (*The Medical News*, December 5, 1896) speaks as follows of this condition: "Among the conditions which render percussion difficult and unsatisfactory in childhood is the peculiar resiliency of the chest at this age. Unless the blow be light and percussion carefully performed, it is very easy to overlook a limited area of dulness which could easily have been found. It is as much or more the sensation of resistance to the finger which we must seek as it is any alteration of the sound. Too hard a blow makes the whole chest reverberate, and prevents the possibility of local differentiation. I find a series of rapid light blows the best method as a rule. But in spite of the greatest care it sometimes happens that a child will pass through an attack of pneumonia without at any time revealing a dulness on percussion. Indeed, it often happens that the affected side is tympanitic rather than dull."

MASSAGE IN CHRONIC HEART DISEASE.—J. Zabludowsk (*Berlin. Klin. Wochenschrift*, 1896, xxxiii., pp. 435-437) advises the employment of massage in cases of chronic heart disease where rest is indicated. When properly applied, the pulse rate is diminished, the quality improves, the sleeplessness is relieved, and a decided change for the better is noticed in a few days. It is essential that the patient lie in a convenient position, so that the part to be acted upon shall be entirely lax. The movements must be energetic, but not rough, and last ten to fifteen minutes; the time of application should be one to two hours after the first meal. All kinds of massage may be used with the exception of tapotement. Massage has also been found serviceable in the treatment of neurosis, sclerosis of the coronary arteries, hypertrophic conditions

resulting from high living, and heart weakness following la grippe. The time of treatment should extend over a period of four to six weeks of daily treatment.

CREOSOTE IN GONORRHŒA.—Asmus (*Meditz. Obozr.*, 1896, No. 10) reports fifty-eight male cases of acute gonorrhœa successfully treated with injections of a 2 to 10 per thousand emulsion of creosote. The discharge quickly decreased, became mucoid, and then ceased altogether. The patients recovered more rapidly than under the ordinary methods of treatment; complications developed but rarely, and no relapses occurred. In addition, creosote seemed to exercise an anæsthetic action on the urethral mucous membrane.

ADENITIS OF THE NECK AND CARIOUS TEETH.—In an editorial appearing in the *N. Y. Med. Journal* a German surgeon, Dr. Starck, is quoted as stating that out of a hundred children which he had examined, ranging from 3 to 12 years of age, suffering from this disease, in fully 41 per cent. the exciting cause was found to be dental caries. Out of this number infectious and hereditary diseases were excluded. He remarks that carious teeth are to be recognised as among the most frequent avenues of infection in children, and further emphasises the practical point that surgeons should extract any carious teeth which may exist in patients upon whom they operate for tuberculous glands of the neck.—*The Laryngoscope.*

BACTERIOLOGY OF THE HAIR.—Dr. L. Brocq (*Journal of Cutaneous and Genito-Urinary Diseases*, September, 1896) says that when the bacteriology of the hair is inquired into various microbes are found in it. Six are, however, discovered quite constantly. These are: (1) a white fungus; (2) a yellow fungus; (3) a bacillus subtiliformis; (4) a bacillus in the form of a boat, staining with difficulty; (5) a special micrococcus, which Sabouraud designates provisionally under the name of micrococcus cutis communis; (6) the spore of Malassez, the flask bacillus of Unna, which he calls the bacillus asciformis. These two microbes, which appear to be the most important, are found in seborrhoics who are not attacked with alopecia areata. No one of these microbes would have the importance of a causal agent in the disease.

NOCTURNAL COUGH ACCOMPANIED BY VOMITING IN INFANTS.—Gastou (*La Médicine*, December 26, 1896) has seen a number of cases of spasmodic cough occurring in young infants in the night time and giving rise to vomiting. Aus-

cultation gave no clue to its origin. Such a cough has often been attributed to a reflex, set up by the intestinal tract, or by some other cause, while a more thorough examination would have shown it to be due to a posterior coryza. It possesses the following characteristics: it is spasmodic, like whooping-cough associated with vomiting, and occurs at night—almost never in the day. · It is seen in young infants who neither blow their nose nor spit. The result is evident. The secretions from the nose, when the infant is lying on its back, drain into the pharyngeal and arytenoid regions and provoke a spasmodic and strangling cough. The treatment is simple. A bit of absorbent cotton is drawn to a point and smeared with borated vaseline and inserted deep into each nostril. The infant sneezes and snuffs and the vaseline penetrates the nasal cavities as far back as the pharynx. If desired, astringent substances, especially antipyrin, may be mixed with the vaseline. This treatment should be carried out three or four times a day.

THE CAUSE OF SUDDEN DEATH AFTER ANTITOXIN INJECTIONS.—Drs. A. Siebert and F. Schwyzer have published the following conclusions: "(1) Antitoxic serum does not seem to be capable of causing threatening symptoms and speedy death, even when brought quickly into the blood current in very large doses. (2) The carbolic acid used in preserving the antidiphtheritic serum must be in such a weak solution as to be entirely unable to cause the characteristic carbolic convulsions produced in every one of our second series of experiments. The absence of these convulsions in patients in cases of sudden death, the entirely different group of symptoms reported in them, and the fact that guinea-pigs and rabbits will survive even very large and concentrated doses of carbolic acid injected into a vein, lead us to discard the possibility of this drug having caused the reported deaths. (3) Even very small quantities of air will cause severe disturbances and ultimate cessation of breathing in every animal experimented upon. These disturbances are entirely analogous to the symptoms reported as preceding the sudden deaths after antitoxin injections. Air is found alongside of the fluid in every syringe used for hypodermic injections, and being pressed under the skin with the fluid may readily come in contact with a punctured cutaneous vein, and so may enter the blood-vessel and the right heart, even before the serum has been absorbed. In view of these facts, and of our experiments, we here express our firm opinion that the sudden deaths reported after antitoxin injections were caused by injected air and not by the antidiphtheritic serum."

A TEN-GRAIN dose of santonin taken with a hot mustard foot-bath at bedtime will sometimes act as an excellent and safe emmenagogue.—*Med. Summary.*

IODIDE OF POTASSIUM IN CROUPOUS PNEUMONIA. — Dr. Werner (*Memorabilien*) holds that iodide of potassium is a specific remedy in the early stages of croupous pneumonia of adults, for, if administered within the first twenty-four hours, it may act so as to abort the disease. He has tried it in eleven cases under these conditions and is satisfied with the results. Dr. Mueller, of the Posen Military Hospital, warmly praises its administration in the early stages of the disease, which he has confirmed in many cases.—*Indian Lancet.*

THE EQUIVALENT OF MIGRAINE.—Dr. A. Barry (*Centralblatt f. innere Medicin*) has attempted to find equivalents of the attacks of migraine in conformity with the views of Prof. Möbius, who regards migraine as a special form of hereditary degeneration, closely related to epilepsy. Dr. Barry reports the history of a case of typical migraine, in which the headaches ceased during a period of three months, and in their place severe gastric pains appeared. At the end of this time the stomach trouble vanished, and the migraine reappeared. The author was able to exclude organic disease of the stomach, and also hysteria and neurasthenia, and he, therefore, regards the gastric pain as a migraine equivalent.—*Journal of Nervous and Mental Disease.*

GASTRIC ULCER TREATED EXCLUSIVELY BY RECTAL NUTRITION.—(E. Ratgen, *Deutsch. med. Woch.*, December 27, 1896.) Having become dissatisfied with the methods hitherto employed for the treatment of gastric ulcer, that is, hot applications, liquid diet, and various drugs, either analgesics or alkalies, for two or three weeks, which, unfortunately, give no absolute assurance of cure, the author accordingly sought for something which would justify him in promising his patients permanent improvement. He therefore determined to experiment more thoroughly with the so-called deprivation cure, that up to the present time only had been resorted to when all other means had proved ineffectual. He diagnoses gastric ulcer from the following symptoms: (1) The period of the appearance of the subjective symptoms of pain after eating; (2) the painful pressure point in the epigastrium and in the back just to the left of the vertebral column at the level of the twelfth dorsal vertebræ; (3) the hæmorrhages of long

or short duration. As soon as the diagnosis is made and the patient weighed, he commences the treatment. This consists of withdrawal of all nourishment by the mouth for a period of ten days, during which time food is administered exclusively by the rectum, and at the same time the patient must observe absolute rest in bed. In case of pain, hot applications are used; no drugs whatever are employed; water and various indifferent teas are used to quench the thirst; occasionally a little cognac is also given. Altogether he has tried this method in 55 cases—53 women and 2 men—usually between 15 and 30 years of age. Alkalies are not employed for the reason that the stomach, in a period of rest, does not secrete acid, nor does the author believe that constant alkalinity of the gastric juice is necessary to secure healing. In no case must the soft sound be used during the treatment. One of the contributing causes, according to his experience, is the dislocation of the stomach, which consists of a low position of the greater curvature and sometimes of the lesser curvature. Of course, this condition is the common result of tight lacing.—*International Medical Magazine*, April, 1896.

THE USE OF GAUZE IN THE TREATMENT OF POST-PARTUM HÆMORRHAGE.—Dr. Schaeffer (*Revue Obstét. Internat.*, December 1, 1896) objects to gauze as a material for uterine tampons in case of flooding. There is no danger of sepsis, if impregnated with iodoform or some other antiseptic. If, as often happens, the tampon fails to stimulate uterine contractions, and if, when the bleeding is from a lacerated cervix, the plug does not cause the torn artery to close by thrombosis, the gauze increases the danger, for it acts as a capillary drain and takes up much blood. As the tolerance of hæmorrhage is very irregular in different subjects, and an apparently trifling loss will kill certain women, the best rule in flooding is not to allow one drop to be shed that can be saved. Gauze, above all if absorbent, takes up many drops of blood at least. Dr. Schaeffer uses non-absorbent gauze, prepared by impregnating it with gutta percha. It may be mixed with iodoform or airol. By rolling it up into a small ball, it can be passed into the uterus, which it distends without absorbing any more blood. The gutta-percha gauze retains its elasticity, and hence Schaeffer finds it useful in inducing abortion.

CURETTAGE AS A ROUTINE MEASURE AFTER ABORTION.—In the *Buffalo Medical Journal*, August, 1897, Goldberg makes a plea for the routine treatment of abortion by curettage of the uterus. Although deaths after abortion are rare, yet

subinvolution and displacement, and diseases of the endometrium and connective tissue, often enough follow it. The bad results are in most instances traceable to the retention of parts of the ovum or membranes. It is most difficult to determine whether or not the uterus has completely emptied itself after an abortion during the early months of pregnancy, and by making use of a curette in every case, the patient is given the best chance of complete recovery. Goldberg has not found it necessary always to tell his patients that a curettage was to be performed, and does not employ an anæsthetic. In all cases he uses a Sims' sharp curette, and has never seen any accident result from it.

INFLUENCE OF PATERNAL ALCOHOLISM ON THE INFANT.—Fieux (*Journ. de méd. de Bordeaux*, No. 11, 1827) has recorded the case of a woman married to an alcoholic, who in nine years had five children, all weak and small at the time of birth. Four died in a few days, and one lived to the age of four years. The mother herself is robust, and enjoys good health. She was deserted by her husband, and has had two children by another man, who is healthy and sober. Both these children are healthy and well nourished, and one is now four years old. There was no evidence of syphilis in the case, and Fieux thinks that it affords a clear demonstration of the evil effects on the progeny of alcoholism in the father. A similar effect is sometimes seen in paternal tuberculosis. In all cases of habitual fœtal or neonatal death it is well to make special enquiry into the condition of the father as well as the mother.

THE TREATMENT OF VOMITING IN PHTHISIS.—Mathieu (*Sem. Méd.*, December 2, 1896), after pointing out that as a rule little benefit is experienced by the use of opiates and counter-irritants in the treatment of vomiting after food in phthisis, these methods being directed to lessening cough, says that attention should really be paid to the gastric mucous membrane. He has obtained excellent results from small pieces of ice given immediately after meals, and equal success from chloroform water and menthol, after food. Attacks of cough are thus lessened or suppressed, and do not cause vomiting. Ferrand stated that vomiting was often due to exaggerated sensibility of the pharynx, and he uses in such cases a solution of potassium bromide in glycerine to the throat, preferably before food.

THE USE OF THYROID EXTRACT AND ITS SUBSTITUTES.—The thyroid gland having become a recognised and valuable therapeutic agent in the treatment of several grave, although comparatively rare, affections, there have naturally been many studies made with the object of decreasing the bulk of the ordinary dose and of preparing the gland or its extract so that its administration would be as unobjectionable as possible. With this in view there have been prepared capsules containing concentrated extract of thyroid, and tablets containing desiccated gland itself have been used for many months with the greatest possible satisfaction in the treatment of myxœdema, cretinism, and obesity of certain types. Not satisfied, however, with the use of the gland in this form, certain German investigators have endeavoured to isolate from it its so-called active principles and to market these derivative substances in small bulk, accompanied by the statement that they in every way represent the activity of the gland itself. Clinical results, however, do not indicate that their theoretical views concerning the activity of these derivatives are correct; and not only is this true, but careful physiological study indicates positively that their influence upon general bodily metabolism is quite different from that exercised by the complete gland. It seems evident, therefore, that the entirely unobjectionable whole gland prepared in desiccated powder or capsule or in compressed tablet is the only means by which we ought to attempt to treat myxœdema and similar conditions in which this animal substance has been found useful.—*Ther. Gazette.*

JONNESCO'S METHOD OF NEPHROPEXY is described and illustrated in his new journal, the *Revista de Chirurgie*, published at Bucharest (No. 4). After an incision parallel to the twelfth rib, or if too short the eleventh, the kidney is brought up to the wound. The adipose capsule is detached and turned back from the entire outer side of the kidney, which is then fastened to the rib by three double silk threads, or better still by two U-shaped pieces of silver wire, each end inserted separately with an Emmett needle passing through the skin, through the M. sacrolumbaris, the lower aponeurosis, and through the fibrous capsule on the rear side of the kidney, through the renal parenchyma 1·5 c.m. from the outer side of the organ, then through the fibrous capsule on the other surface through the periosteum of the twelfth rib and finally out again through all the layers, 3 cm. beyond the wound. The ends of the threads are tied over a long roll of sterile gauze at each end and in the middle,

with the ureter in its normal position. He has performed this operation ten times on patients and many times experimentally. He is careful to keep his patient in bed twenty days, and removes all the threads or wires the tenth day, thus obviating all the inconveniences of permanent threads. The adhesions between the decorticated parenchymatous surface, the rib and the muscular tissues, form a remarkably firm support, and "all the disadvantages of other methods are absent."

INFLUENCE OF COLD BATHS IN DELIRIUM TREMENS.—Lettule (*Centralbl. für. Ges. Ther.*) recommends as a sedative in delirium tremens a cold bath of 65° F., the patient being immersed in the water to his shoulders, while water of the same temperature is poured over his head. In a severe case in which large doses of morphin subcutaneously and chloral by the mouth had failed to give sleep in two days, and death was expected, a bath of the temperature of 65° F. increased in the first three minutes cyanosis and excitement. In six minutes the aspect of the patient completely changed. His excitement disappeared, he seemed to awake from a dream, asked where he was, drank eagerly two glasses of warm wine, and wanted to sleep. He was placed in bed and immediately fell asleep. The following day, on account of recurring excitement, it was necessary to repeat the bath four times. There was no further delirium and the patient recovered. In a second case it was necessary to leave the patient twelve minutes in the bath, when as suddenly as before there was quiet, thirst and a desire for sleep, followed by complete recovery in two or three weeks.—*Med. News.*

THE PERNICIOUS INFLUENCE OF THE CORSET.—Dr. Hirsch, in the *Frauenarzt*, April, 1897 (*Indépendance médicale*, June 23), states that in many young girls chlorosis would not assume so grave a character if they were not subjected to the pernicious habit of wearing corsets. The best iron baths will have no effect whatever if the body is habitually squeezed into a corset. It is useless to induce deep respiration by bathing if, after the bath, free respiration is to be hindered by a corset. Of what use is it, the author asks, to excite the appetite if the stomach is squeezed? The defect in respiration results in troubles of the circulation as well as in cardiac obstructions and disturbances. Dr. Hirsch thinks the corset should be abandoned; that a "wasp-waist" is no longer considered the ideal of beauty; and that we may become accustomed to another form. The knowledge of having a healthy body

should facilitate the adoption of the new mode of dressing. Then it will be found that the intensity and duration of chlorosis will diminish, for gymnastic exercises and games have no value unless the body is able to move freely and without restraint. Then it will become so strong and erect that it will not be necessary to resort to a corset.—*N. Y. Med. Journal.*

ANEURISM AND SYPHILIS. — A study of the connection between aneurism and syphilis in the *Annales de Drem. et de Syph.*, for January, by Prof. G. Etienne (*Med. News*) announces that 70 per cent. of 376 cases examined were found to have syphilitic antecedents, and this is a minimum proportion, as it is so difficult sometimes to detect traces of old syphilis. With most of the aneurisms the infection dates from five to twenty-five years. No histological difference between the aneurism of syphilitics and non-syphilitics was noted with rare exceptions. Mercurial treatment is successful if the gummatous infiltration is still susceptible to absorption without leaving scleroma behind it, so that the tissues can resume their elasticity. When the lesion has advanced beyond this stage, specific treatment is ineffectual. The article concludes with the statement that aneurisms, therefore, with tabes and general paralysis, can be included in what Fournier calls para-syphilitic affections.—*N. Y. Med. Times.*

FLOATING KIDNEY IN CHILDREN.—Comby asserts that the accepted causes of floating kidney must be erroneous in many cases, as he has found it occur quite frequently in children since he began to look for it. This shows that the condition in adults may date from the earliest years and may be congenital. The *Bull. Soc. Méd. des Hop.*, May 27, contains his observations of six cases, ranging from infants to girls of 14, and he urges others to co-operate in obtaining further information in regard to this condition in children.

DOSAGE OF COLCHICUM IN GOUT. — Professor Schultz announces that the failures in colchicum in gout are due to errors in the dosage, and he announces as the result of considerable research that the best formula is the tincture of colchicum seeds diluted with alcohol 1-10, of which 20 to 40 drops are taken during the day.—*Semaine Méd.*

NOTES ON NEW PREPARATIONS, &c.

Potassium Permanganate Hypodermic "Tabloids" (2 gr.), Burroughs, Wellcome & Co.—In view of the evidence of the value of potassium permanganate as an antidote to opium and morphine poisoning, hypodermic "tabloids," each containing 2 gr. of the drug, are now issued by Burroughs, Wellcome & Co.

It is stated that one grain of potassium permanganate is an antidote to one grain of morphine sulphate, even when the poison is absorbed into the system, and upon this the dosage is founded. The usual strength of the injection is 1 in 100; these tabloids are readily soluble.

The same firm have sent us **Hypodermic "Tabloids" of Ergotinine Citrate $\frac{1}{100}$ gr. and Strychnine Sulphate $\frac{1}{30}$ gr.**—The combination is recommended in uterine hæmorrhage, in vaso-motor neurosis, cephalalgia and hemicrania. Ergotinine is also said to be valuable hypodermically in diabetes insipidus, and paralysis of the bladder. The full dose of ergotinine citrate is $\frac{1}{30}$ gr., but one tabloid should be given first, and repeated if necessary. The use of the tabloid prevents over-dosage, as the amount of its constituents is accurately adjusted; these tabloids may be also administered by the mouth.

Izal Preparations.—Messrs. Newton, Chambers & Co., have sent us samples of Izal soaps, ointment, embrocation, tooth powder, lozenges, &c.

We have examined most of these, and consider the various toilet preparations are extremely good and elegant. The soaps are very satisfactory for use with hard water, and form a good lather. We would especially commend the Izal embrocation, since much harm may and is often done by rubbing a bruised and possibly abraded limb with ordinary liniment; in fact we have known of the occurrence of erysipelas after energetic rubbing with soap liniment in consequence of a sprain.

Palatinoids of Duodenin. Messrs. Oppenheimer, Sons & Co.—These are prepared from the excretion from the glandular system of the duodenum, and contain various enzymes that are similar to steapsin, trypsin, and amylopsin of the pancreas. They are therefore recommended as useful in promoting the assimilation of proteid matter, farinaceous foods, and fats, and should prove useful in certain forms of dyspepsia.

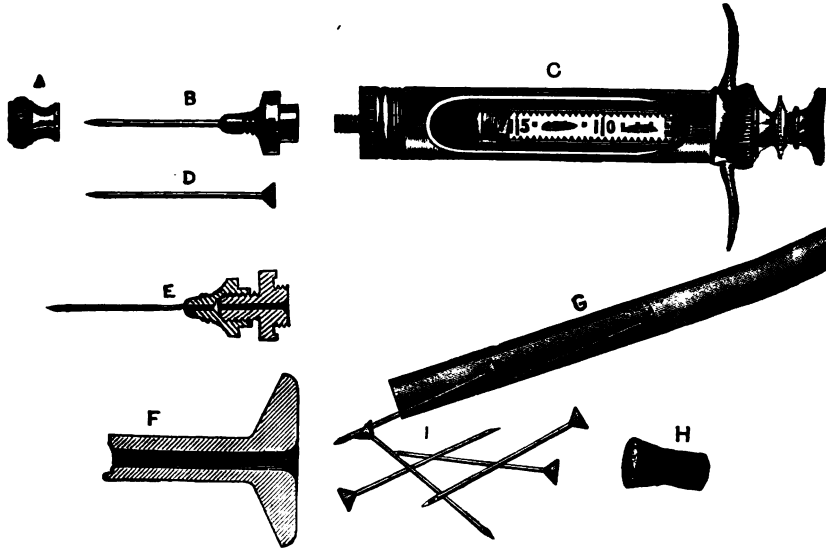
The same firm has sent us some **Palatinoids of Succinate of Iron**, each containing 5 grs. This preparation has been highly recommended by several physicians, to prevent the formation of gall stones. From the reports of Drs. Buckler and Osterlony, this drug is credited with the power of oxidising cholesterin, and so preventing the formation of gall stones. The treatment, however, must be supplemented by some mild aperient. The palatinoid being kept hermetically closed from the atmosphere, decomposition of the succinate of iron is prevented.

Hopkinson's Liq. Colchicinæ Salicyl.—Messrs. Bass, Bros. & Co. have recently become sole makers of this preparation, which contains $\frac{1}{32}$ of a grain of salicylate of colchicine in each fluid drachm. It is said to be successful in cases of rheumatoid arthritis, chronic rheumatism, gout, neuralgic joint affections, and lumbago. It causes no depressing effect whatever, and better results are obtained than with colchicum wine and salicylic acid or other compounds. The dose is a teaspoonful, diluted, twice a day between meals.

"**Apenta,**" the new aperient water introduced by the Apollinaris Company from their springs at Buda Pesth, has just received very warm commendation in a paper read before the Moscow Society for the Preservation of Public Health, by Professor W. S. Bogoslowsky, president of the Society and Director of the Pharmacological Institute of the Moscow University. He states that he found systematic treatment with "Apenta" Water especially indicated in constipation resulting from atony of the bowels, and that its use does not give rise to subsequent constipation. He found its action more gentle than that of some other bitter waters, which circumstance he believes to be due to the fact that it contains less calcium sulphate and no magnesium chloride. He gives detailed accounts of several cases in which he obtained admirable results from systematic treatment with "Apenta" Water.

Messrs. Parke, Davis & Co. have sent us one of their improved **Aluminium Hypodermic Cases.** This case resembles their former case except that it is fitted with the new Schimmel's patent aseptic needles. The case contains, besides the syringe and needles, six tubes of twenty-five hypodermic tablets. It is, however, to the aseptic needle to which we wish to draw attention, and the principle is explained in the accompanying diagram. The actual needle is quite separate and loose from the nozzle, but a quite tight joint is made by screwing the nozzle on to the syringe. If the needle has

been used for a septic case it can be thrown away after use, as the cost of each separate needle is only threepence. The needles are made of seamless steel, and have been sterilised at a temperature of 300° F., and are supplied in stoppered tube vials of six.



EXPLANATION OF CUTS.—A, cap for adapter when syringe is not in use; B, loose hypodermic needle mounted in butt; C, regular syringe with adapter attached; D, hypodermic steel needle; E, longitudinal section, showing formation of continuous channel by the use of adapter, which screws into ordinary syringe in the same manner as the needle in Improved Hypodermic Case; F, magnified end of needle showing central countersinking of the mounting to permit easy introduction of wire after using; G, seamless aseptic steel hypodermic needles in a tube vial of six; H, stopper for tube vial.

Among the advantages of these needles we would mention that they do not become unsoldered, and are not so liable to break as ordinary ones, and in the event of any block occurring or the needle rusting a fresh one can be inserted at once; they are more easy to clean and no leather washers are used.

The needle end of the syringe unscrews to allow of a tablet being introduced, and the solution made in the syringe itself. An arrangement also exists in the piston rod for tightening up the leather sucker. The whole syringe can readily be taken to pieces for sterilisation. With regard to the hypodermic tablets, we have tried several different preparations, and have been very satisfied with their ready solubility and the accuracy of their composition.

Messrs. Oppenheimer, Son & Co., Ltd., had on view at the Medical, Surgical and Hygienic Exhibition, held at the Queen's Hall in July, a large display of palatinoids and bi-palatinoids. This firm now claim that they are able to supply any drug either solid or liquid (excepting acids and aqueous fluids) in the palatinoid form, and we noticed specimens of amyl nitrite, chloroform, chlorodyne, creasote and ether, which were marvels of elegance and ingenuity. When one realises that it is now possible to enclose a definite quantity of such highly volatile liquids as the above in an air-tight soluble glycerine casket, it must be admitted that we are considerably on the way to "ideal pharmacy." Special attention was drawn by this firm to their preparations of animal substances in palatinoid form, and the claim is put forward—certainly on good scientific authority—that this is the most perfect method of exhibiting these readily decomposible tissues, as it entirely obviates any risk arising from the development of ptomaines, which is likely to happen when such substances are exposed to the air.

An improved form of iron medication is the bi-palatinoid, which externally resembles the palatinoid, but the essential difference is a soluble septum, which prevents readily oxidisable drugs, such as the alkali and iron of Blaud's pills prematurely reacting on each other and thus forming inert compounds. Messrs. Oppenheimer claim that by this means they produce a perfect Blaud's pill, by effecting the liberation of nascent ferrous carbonate in the stomach, and clinical results certainly appear to corroborate their statements.

Another novelty, the latest, most convenient and most complete of hypodermic cases, also attracted attention. It is an aluminium case containing thirteen tubes of hypodermics in a movable metal rack, two ordinary hypodermic needles and one exploring needle. No pestle and mortar are necessary, the hypodermics being instantly dissolved in a few minims of water in the barrel of the syringe. But what practitioners will probably appreciate most in connection with it is, that whichever way it is opened nothing falls out, everything being securely fixed in, so that even when in the pocket none of the contents shake about.

The feature of the exhibition, however, was a unique collection of antiquities referring to medicine and surgery, which was on view in an upper room. The collection consisted of nearly four hundred ancient surgical instruments from the first to the fifteenth centuries, and a large number of terra-cotta votive offerings of ancient Italy. From these instruments one can see that specialism in surgery is not a growth of modern days, for there were to be seen no less than forty-

three instruments which were taken from the tomb of an oculist. Many of these instruments are of delicate workmanship and nearly all bear the name either of the surgeon or maker. The votive offerings or "Donaria," are mostly of terra-cotta, but some are of bronze, and they appear to have been thrown into healing waters by the patient or hung at the shrines of medical deities.

The whole collection formed a valuable contribution to medical history and was greatly appreciated by the profession.

Messrs. John Bale, Sons & Danielsson, Ltd.—This exhibit at the same exhibition was one of the most, if not the most, interesting in the Hall, as was evidenced by the constant succession of visitors who kept the attendants fully occupied in answering questions and supplying their various wants. There were on show many medical and scientific books issued by the printing and publishing department of this enterprising firm, the execution and finish of which were quite up to their usual standard of excellence. The Art Department was also well represented, and in addition to their well known and equally well appreciated Clinical Figures, we noticed a New Series of Lecture Diagrams which were in course of preparation, specially prepared for the use of Students, and Lectures to Nurses and Ambulance Classes. Those we examined were well and accurately drawn, and we have no hesitation in saying that they will be found invaluable helps to those for whom they have been designed. We understand the series of thirteen diagrams are now nearly completed, and it will be surprising if they do not have a large circulation. The photo-process work shown was remarkably good, and the skiagrams would rank with anything of the kind we have seen, while the results of the half-tone blocks were excellent and impressed us with the advantage authors will derive by having their illustrations produced and printed by one and the same firm. Lastly, we would mention the beautiful chromo-lithographs of birds and butterflies executed for a well-known Natural History, issued by one of the best London publishing houses. The drawing and colouring was exquisite, and is a complete answer to such as laud foreign productions to the detriment of British. While such beautiful work can be done at home, no one need even cross the channel to have their wants supplied.

NOTES AND NEWS.

THE Cavendish Lecture, which was delivered on July 2, was largely attended and was followed by the annual conversazione, given by the President and Council to the members of the Society and their friends. Upwards of one hundred members and guests were present. On a platform in the centre of the ward of the new wing, where the meeting was held, a band discoursed classical and other music, while upon either side of the ward were ranged stalls containing exhibits by the well-known firms whose advertisements are to be found in our pages. These stalls formed a great attraction to the majority of those present. In one of the small rooms in the adjoining corridor Mr. Davidson had a display of his various optical appliances, including his ingenious optometer. Altogether, the conversazione was very successful, and the honorary secretaries of the Society, Mr. Neville Wood and Dr. McCann, were to be congratulated upon their efforts in contributing to this result, and for their zeal in carrying out all the necessary arrangements.

THE Festival dinner of the West London Hospital will be held on November 10, His Grace the Duke of Devonshire in the chair. Everyone interested in the charity must wish that a record sum will, upon this occasion, be raised, thus enabling something to be done towards discharging the debt upon the new wing. "Hope deferred maketh the heart sick." That, it is to be feared, is the condition at present of those who for the past six months or more have been looking forward to the new wards being added to the service of the hospital. Even the optimism of the optimist in these matters has probably failed to prevent him from regarding with gloomy misgivings the *laisser faire* policy which seems to pervade the inner working of the hospital. Languishing in their mournful emptiness, the new wards are also already beginning to show the defacing effects of time; and yet what has been done, so far, to justify their existence? The ghosts, as it were, of the echoes of the brilliant assemblage of May, 1896, haunt one at every turn in the new wing; they oppress one with the memories of lost opportunities. Nearly eighteen months have passed since the royal pageant was held in the hospital; it was hoped that the function organised under such favourable auspices would have been the commencement of a new era of prosperity for the institution; but somehow it seems that fate has decided otherwise. The presence of royalty at the

bazaar has only proved to have had meteor-like results. That opportunities have been lost of making more use of the splendid advertisement accruing from the opening ceremony of the bazaar is a matter respecting the truth of which the present condition of the new wing is, undeniably, a silent, melancholy, and impressive witness.

IT is well to look these facts in the face, however unpleasant it may be to mention them. Nevertheless, it should not be forgotten that the Society is greatly indebted to the Hospital for many things, and by making known the urgency which exists for striking out a new line of active policy at the present crisis in the history of the institution, it is possible that some of the members may be stimulated to come forward and proffer valuable aid.

BUT looking further ahead a little, another difficulty suggests itself, and that is with reference to the question of maintenance after the new wing has been opened, and the beds added to the service of the hospital. Here again the paramount necessity of an active policy seems to be the only solution. The addition of seventy beds will involve a largely augmented expenditure of funds, and an increased nursing staff, among other matters, will be requisite; in short, the hospital income will probably have to be increased as much as forty or fifty per cent. before anything like a substantial financial position could be attained.

AN event took place recently which should not be allowed to pass without notice here—I allude to the marriage of Dr. Symons Eccles to Miss Jackson, on August 10. It is not needful for me to remind the members that it was to Dr. Eccles, our President in 1896, that we are indebted for the idea of adding this JOURNAL to the undertakings of the Society. The members have now in the JOURNAL a common bond of union, and for this we have undoubtedly to thank Dr. Eccles. I am sure that the members of the Society generally, cordially wish him all the health and happiness in his married life that he may desire.

THE Cavendish Lodge (2620) enters upon the second year of its existence on October 20, 1897, when the installation meeting will be held at the Royal Palace Hotel, Kensington, at 4 p.m. The banquet will take place at 7.30 p.m. The

Lodge is making excellent progress, having already attracted to its fold many members of the Society who were desirous of joining the Craft. It may also be again pointed out that the Lodge is not exclusively a medical one, that is to say, it is quite open to laymen. For example, one of the lay members is Major McMahan, F.R.S., Professor of Mathematics at the Royal Military Academy, Woolwich.

AT the last meeting of the JOURNAL committee, our editorial secretary, Mr. Bidwell, asked that he might be relieved of the duties of his office, his time being now too much occupied with professional and other work to enable him to attend properly to the advertisement department of the JOURNAL.

THIS announcement will be certain to be received with regret by the members, to the majority of whom it will probably be unknown how much Mr. Bidwell has done in making a success of his department. No steps have so far been taken in the appointment of a successor, but the matter will be dealt with at a meeting of the JOURNAL committee to be held in November.

DR. H. P. POTTER, our new president, is one of the original members of the Society. He has also been a vice-president and a member of the Council. As the medical superintendent of the Kensington Infirmary, he has an excellent field for obtaining valuable clinical material for the meetings, and the record of his past work for the Society shows that he has well earned the honour of the presidential chair, to which he was unanimously elected.

IN these days of the depletion of medical incomes, it is refreshing to glance backwards and learn something of the "good times" enjoyed by our forefathers in medicine. And, be it observed, there is no necessity to go very far in this retrospect, for the comparatively recent reign of Queen Anne contains more than enough for our purpose. Medical men in the reign of this excellent sovereign seem to have had a glorious time of it. Then it was that no physician with the slightest pretension to a practice could manage without his coach and four, or even six horses. Fancy, now-a-days, physicians, surgeons, and general practitioners driving round to see their patients in this style! Doctors first began to use carriages in London during the reign of Charles II.; previously

to that they visited their patients on horseback, and, curiously enough, perhaps out of compliment to their lady patients, they always sat sideways on their horses — like women. Another remarkable custom among our forefathers was, that while driving in their carriages during cold weather they used muffs—also like women. These muffs were of large calibre, sufficient to cover the forearms, and the idea was that the muff helped to preserve the delicacy of touch and nice sense of discrimination when feeling the pulse of patients. In these days of antiseptics and strong solutions of carbolic acid, medical men have not the same chance of taking care of their hands.

But Queen Anne perpetrated a most atrocious act during her reign. She not only employed a quack "oculist," but even conferred upon him the honour of knighthood. Sir William Read, the quack in question, was originally a tailor or a cobbler; he could not read, but he is said to have possessed an uncommon share of impudence. That this was the case is quite conceivable, for otherwise he could not have gained the very large practice which he is reported to have had.

If medical men, however, in earlier days had a "good time of it," so had the quacks. Nothing came amiss to the horde of the latter gentry which preyed upon the gullible public. To show the extent to which they pushed their impudence, it is pointed out by Addison in the *Tatler* that he remembered, after an earthquake which visited England, a quack going round selling pills which he said "were very good against an earthquake." What the pills were going to do with the earthquake, or what the pills were going to do with the people when the earthquake came, are matters which do not seem to have been discussed. Nevertheless, a great trade was done in "earthquake pills." Now-a-days we have no earthquakes in England, but there are plenty of quack pills, and apparently there are plenty of people who swallow them.

The West London Hospital Dance, which was held at the Queen's Hall, Langham Place, on May 31, resulted in the addition of nearly £120 to the Building Fund of the new wing.

P. D.

REPORT FOR THE SESSION.

Presented by the Council at the 15th Annual Meeting, July, 1897.

In presenting the Annual Report for the Fifteenth Session the Council have great satisfaction in recording another year of great prosperity and progress. The total membership of the Society is 466. The number of new members who have joined the Society has reached the satisfactory total of 65, while the sustained interest in its meetings is demonstrated by an average attendance of 49.

The overcrowding at the clinical evenings has again brought forward the question of enlarged accommodation which it is hoped may be satisfactorily dealt with for the ensuing session.

The West London Medical Journal has been the subject of wide-spread interest and favourable comment, and bids fair to fully realise the hopes of its founders.

The Annual Dinner was held on June 11, at the Trocadero Restaurant, nearly 100 members and guests being present. The occasion was specially marked by the presence of Lord Lister, an honorary member of the Society, whose elevation to the peerage has been hailed throughout the profession as of a happy augury.

The Cavendish Lecture was delivered by Sir J. Williams, Bart., who dealt with his subject in a characteristically broad and scientific spirit. After the lecture the President and Council had the pleasure of entertaining over 100 members and friends at a Conversazione. The exhibition of medical, surgical and dietetic products, which it is hoped may now be considered as an annual custom, was a valuable and instructive feature.

Thanks to the unremitting energy of the Treasurer the finances of the Society remain on a satisfactory basis, and the donation of £5 5s. has been again made to the West London Hospital.

The Council have again great pleasure in expressing the hearty thanks of the Society to the House Committee of the Hospital for the use of the Board Room for its meetings, and for one of the new wards for the Cavendish Lecture. They also desire to thank the Lady Superintendent (Miss Hardy), and the Secretary (Mr. R. J. Gilbert) for their unvarying courtesy and kindness.

It is with deep regret that the Council have to record the deaths of Sir Spencer Wells, Hon. Member; Mr. J. Savage, Member of the Council; Mr. W. Ainsworth, Original Member; Mr. R. Mahon and Mr. L. Parnell, Ordinary Members; and Dr. James Andrew, the Cavendish Lecturer of 1889. Eight resignations have been received, and four members have been removed from the list for non-payment of subscriptions under law 27.

The following papers and cases have been brought before the various meetings:

PAPERS.

PRESIDENTIAL ADDRESS.—Some Effects of a Lack of Muscular Development.

Mr. BOWREMAN JESSETT.—A Case of Fæcal Fistula Treated by Enterectomy.

Dr. MANSELL MOULLIN.—Intra-peritoneal Hæmorrhage in Connection with Pregnancy.

Dr. TYSON.—A Plea for the More Precise Clinical Classification of Disease.

Mr. PAGET.—Six Cases of Strangulated Hernia in Infancy or Early Childhood.

DISCUSSION ON THE MENOPAUSE.—Opened by Dr. ROUTH and Mr. C. TUKE. Discussion continued by Drs. H. CAMPBELL, M. MOULLIN, H. SUTHERLAND, CAMPBELL POPE, F. MCCANN, C. CHAPMAN, FORBES ROSS, and Mr. MCADAM ECCLES.

Dr. GOSSAGE.—The Serum Diagnosis of Typhoid Fever.

Dr. H. CAMPBELL.—The Pathology and Treatment of Emphysema.

Mr. BIDWELL.—The Value and Safety of Laparotomy in Doubtful Abdominal Cases.

Dr. SNOW.—Anticipatory Gland Excision.

CLINICAL CASES.

Dr. H. SUTHERLAND.—Extensive Varicose Veins.
Supernumerary Nipple.
Congenital Absence of Iris.
Epilepsy of Short Duration.
Premature Greyness of the Hair.

Dr. CAMPBELL POPE.—Fracture of Lower Epiphysis of Humerus, with Skiagram.

Mr. KEETLEY.—Sarcoma of Male Breast.
Congenital Dislocation of Hip.
Congenital Dislocation of Hip after Operation.

Dr. CHAPMAN.—A Cretin.
Thoracic Aneurism.

Dr. ROBINSON.—A Case of Ovariotomy with Pedicle Clamped in Abdominal Wound.

Dr. PATON.—A Case of Nephro-lithotomy with Stone Removed.

Dr. SEYMOUR TAYLOR.—Right Hemiplegia.
Hydrocephalus Surviving to Puberty.
Congenital Spastic Paraplegia.
Fracture of Skull.

Dr. G. JOHNSTON.—Facial Hemiatrophy.

Dr. CLIPPINGDALE.—Congenital Ichthyosis.

Dr. PERCY POTTER.—Tumour of Upper Jaw.
A Case of Scurvy.

Mr. MCADAM ECCLES.—Rodent Ulcer of Axilla.
Symmetrical Nodules over Ulna.
Patient after Removal of Tumour of Upper Jaw.
An Exostosis Family.

Mr. S. EDWARDS.—Nephro-lithotomy.
Papillomatous Dermatitis of Anus.

Mr. BIDWELL.—Operation for Extensive Epithelioma.
Primary Chancre of Cheek.
Cyst of Thyro-glossal Duct.
Tuberculous Tumour.

Dr. BURRELL.—Two Cases of Leucodermia.

PATHOLOGICAL SPECIMENS, ETC.

Dr. PATON.—Rupture of the Bladder.

Mr. PAGET.—Dentigerous Cyst of Lower Jaw.
Fibro-cellular Tumour of Ovary.

Mr. J. H. MENZIES.—Skiagram of Glass Embedded in Hand.

Mr. MCADAM ECCLES.—Excision of Part of Ascending Colon.
Section of Rodent Ulcer.

Dr. GOSSAGE.—Demonstration of Widal's Reaction in the Blood from a case of Typhoid Fever.

Signed on behalf of the Council,

W. BRUCE CLARKE, *President.*
NEVILLE WOOD, } *Hon. Secretaries.*
F. J. McCANN, }

STATEMENT OF ACCOUNTS FOR FINANCIAL YEAR ENDING MAY 31st, 1897.

Dr.	£ s. d.	£ s. d.
To Balance in hand from last Account		45 1 2
,, Subscriptions, including arrears, received	107 5 0	
,, Subscriptions paid in advance	3 0 0	
From Dinner Fund, 1896	4 7 2	
		114 12 2
To Subscriptions in arrear, May 31st, 1897	29 5 0	
,, Subscriptions in arrear previous to May 31s 18 ..	10 15 0	
		40 0 0
		£199 13 4

Cr.	£ s. d.	£ s. d.
By Messrs. Bale & Sons, Publishing and Distributing Vol. vii. of the Transactions		41 17 1
,, Grant to West London Medical Journal		25 0 0
,, Printing and Stationery :—		
Messrs. Churchman	16 5 5	
Editorial Secretary for Annual Report	4 10 0	
		20 15 5
,, Postage, &c. :—		
Mr. Bidwell, Session 95-96	0 16 0	
Dr. McCann, Session 96-97	0 10 0	
Dr. Wood	1 13 8	
Editorial Secretary, Postage of Agendas, &c. ..	1 3 2	
Messrs. Churchman	10 0 0	
Treasurer, for Stamped Envelopes	2 13 0	
		16 15 10
,, Refreshments :—		
Grocer	3 2 6	
Baker	0 6 0½	
Milkman	0 11 0	
		3 19 6½
,, Servants' Wages		4 0 0
,, Kensington Stores for Platform, &c., Cavendish Lecture		3 4 6
,, Donation to West London Hospital		5 5 0
,, Subscription, *Medical Press and Circular*		1 3 0
,, Carriage of Books, &c., for Library, from Bristol ..		0 17 2
,, Sundries		0 2 4
		122 19 10½
,, Balance at Bank, May 31st, 1897 .. .. £34 6 5		
,, Less unpresented cheque 1 13 8		
	32 12 9	
,, Cash in hands of Treasurer	4 0 8½	
		36 13 5½
,, Arrears of Subscriptions		40 0 0
		£199 13 4

Audited and found correct,

(Signed) CHARLES ANDREWS.
F. R. MALLARD.

June 12th, 1897.

OFFICERS AND COUNCIL.

SESSION, 1897–8.

President.

DR. PERCY POTTER.*

Vice-Presidents.

(HONORARY)

DR. CHARLES WELLS.
MR. SWINFORD EDWARDS.
DR. DONALD HOOD.
DR. R. J. BANNING.
DR. SYMONS ECCLES.

MR. BRUCE CLARKE.
MR. R. LAKE.
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MR. L. A. BIDWELL.
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DR. ANDREW ELLIOT.*
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DR. G. D. ROBINSON.*
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Secretaries.

DR. F. J. McCANN.
MR. McADAM ECCLES.*

Librarian.

MR. C. B. KEETLEY.

Editor of Journal.

MR. H. PERCY DUNN.

Editorial Secretary of Journal.

MR. L. A. BIDWELL.

* Did not hold similar office last year.

PAST PRESIDENTS OF THE SOCIETY.

1882-83. E. HART VINEN, M.D.
1883-84. J. W. L. THUDICHUM, M.D.
1884-85. F. LAWRANCE.
1885-86. W. B. HEMMING.
1886-87. F. H. ALDERSON, M.D.
1887-88. C. R. B. KEETLEY.
1888-89. W. TRAVERS, M.D.
1889-90. H. CAMPBELL POPE, M.D.
1890-91. T. GUNTON ALDERTON.
1891-92. C. WELLS, M.D.
1892-93. F. SWINFORD EDWARDS.
1893-94. DONALD W. C. HOOD, M.D.
1894-95. R. J. BANNING, M.D.
1895-96. A. SYMONS ECCLES, M.B.
1896-97. W. BRUCE CLARKE.

CAVENDISH LECTURERS.

1884. TIMOTHY HOLMES.
1885. J. S. BRISTOWE, M.D., F.R.S.
1886. JONATHAN HUTCHINSON, LL.D., F.R.S.
1887. SIR ANDREW CLARKE, BART., M.D., F.R.S.
1888. SIR WILLIAM STOKES, M.D.
1889. JAMES ANDREW, M.D.
1890. ALEXANDER OGSTON, M.D.
1891. T. LAUDER BRUNTON, M.D., F.R.S.
1892. SIR CHARLES CAMERON, M.D.
1893. HENRY MORRIS, M.B.
1894. SIR WILLIAM BROADBENT, BART., M.D.
1895. SIR J. CRICHTON BROWNE, F.R.S.
1896. THOMAS BRYANT.
1897. SIR JOHN WILLIAMS, BART., M.D.

LIST OF MEMBERS

(Corrected to September, 1897.)

Honorary Members.

The Right Hon. Lord LISTER, P.R.S., 12, Park Cresent, W.
Sir WILLIAM JENNER, Bart, G.C.B., D.C.L., LL.D., F.R.S.
Sir JAMES PAGET, Bart., D.C.L., LL.D., F.R.S., 5, Park Square, West, N.W.
JONATHAN HUTCHINSON, LL.D., F.R.S., 15, Cavendish Square.
His Excellency JOHN DUNCAN, M.D. (of St. Petersburg).
Prof. BURDON SANDERSON, M.D., F.R.S., Oxford.

Honorary Vice-Presidents.

(Not Ex-officio Members of Council.)

J. W. L. THUDICHUM, M.D.
F. LAWRANCE.
F. H. ALDERSON, M.D.
C. B. KEETLEY.
W. TRAVERS, M.D.
H. CAMPBELL POPE, M.D.
T. GUNTON ALDERTON.

Members, September, 1897.*

* The Secretaries request that they may be informed immediately of any inaccuracy in the list or of any change of address.

The abbreviations P., T., V.P., S., C., E.P., A., L., E.J., *and* E.S.J., *are attached to the names of those who have respectively held the offices of President, Treasurer, Vice-President, Secretary, Member of Council, Editor of Proceedings, Auditor, Librarian, Eaitor of the* JOURNAL, *or Editorial Secretary of the* JOURNAL. *The date before each name signifies the date of election, and the letters* O.M. *signify original member.*

1886	Abraham, P., M.D. (V.P., S., C., E.P.)	...	2, Henrietta Street, Cavendish Square, W.
1896	Achard, A. L., M.D.	...	9, Blandford Street, W.
1896	Ackland, R. C.	...	13, Saville Row, W.
1896	Adams, James, M.D.	...	Springwell, Barnes, S.W.
1892	Addinsell, A. W., M.B.	...	30, Ashburn Place, S.W.
1886	Albert, H. Louis	...	49, Sloane Street, S.W.
O.M.	Alderson, F. H., M.D. (P., V.P., C.)	...	Southerton House, 38, Glenthorne Road, Hammersmith, W.
1890	Alderson, F. H., M.B.	...	2, Holland Road, W.
O.M.	Alderton, T. Gunton (P., T., V.P., S., C.)	...	82, The Grove, Hammersmith, W.
1889	Alexander, R. Reid, M.D.	...	The Asylum, Hanwell.
1884	Anderson, W. M., M.B.	...	Norville, Alleyn Park, W. Dulwich, S.E.
1885	Andrews, Charles (A.) (C.)	...	92, Hammersmith Road, W.
1884	Appleton, T. A.	...	46, Britannia Road, Fulham, S.W.
1895	Ashe, W. P., M.D.	...	23, Cadogan Gardens, S.W.
1885	Atkinson, T. R.	...	1, West Cromwell Road, S.W.
1893	Austen, Harold, M.D.	...	25, Mattock Lane, Ealing, W.

1885 Ayling, Arthur H. W. ... Cleveland House, Park Street, Wellington, Salop.

1896 Bailey, C. F., M.D. ... 35, Highbury Grove, N.
1896 Bailey, H. F. ... The Hollies, Lee Terrace, Blackheath, S.E.
1897 Baines, E. M.B. ... 11, Cranley Place, S.W.
1896 Baker, E. C., M.B. ... 5, Gledhow Gardens, S. Kensington, S.W.
1891 Baker, W. H. ... 40, Norfolk Terrace, Bayswater, W.
O.M. Baldock, A., M.B. ... 180, Earl's Court Road, S.W.
1885 Ball, James B., M.D. (V.P., C.A.) 12, Upper Wimpole Street, W.
1883 Ballance, C. A., M.S. ... 106, Harley Street, W.
1888 Barbour, Jas. M., M.B. ... 18, Nevern Road, S.W.
O.M. Barnes, E. C. (V.P., C., A.)... 194, Hammersmith Road, W.
1892 Barrett, A. K. ... County Asylum, Bicton Heath, near Shrewsbury.
1887 Bartlett, Edward ... 38, Connaught Square, W.
O.M. Barton, J. K. ... 2, Courtfield Road, Gloucester Road, S.W.
1889 Bateman, A. G., M.B. ... 49, Devonshire Street, W.
1896 Batten, F. E., M.D. ... 124, Harley Street, W.
1888 Batten, Rayner D., M.D. (C.) Campden Lodge, Campden Hill Road, W.
1886 Battiss, W. S. ... Whitford Lodge, Dorking.
1883 Battle, W. H. ... 2, Mansfield Street, Portland Place, W.
1893 Beauchamp, Sydney, M.B.... 146, Cromwell Road, S.W.
1891 Belben, F., M.B. ... Hoo Menry, Branksome Chine, Bournemouth.
O.M. Benham, R. F. ... 9, Castletown Road, West Kensington, W.
O.M. Bennett, C. H., M.D. (A.) ... College House, Hammersmith, W.
1894 Benson, G. Vere ... 13, Queen Anne's Grove, Bedford Park, W.
1891 Bidwell, L. A. (S., C., E.P., E.S.J.) ... 59, Wimpole Street, W.
1896 Bienemann, A. J., M.B. ... 64, Shepherd's Bush Green, W.
O.M. Bird, W., J.P., D.L. ... Bute House, Brook Green, Hammersmith, W.
1896 Bishop, T. H., M.B. ... 4, South Parade, Bedford Park, W.
1889 Blacker, A. B., M.D. ... 15, West Eaton Place, S.W.
1885 Blenkinsop, W. H., M.B. (C.) 7, Powis Gardens, Bayswater, W.
1892 Bluett, G. M. ... 95, Holland Park Avenue, W.
1894 Bolton, A. G., M.B. ... 1, Cheniston Gardens, Kensington, W.
1893 Bonney, W. Augustus, M.D. 100, Elm Park Gardens, S.W.
1889 Bontor, S. A., M.D. ... Great Berkhampstead, Herts.
1897 Booth, R., M.B. ... 12, Gordon Terrace, Munster Road, Fulham, S.W.
O.M. Bott, Henry ... Brentford, Middlesex.
1889 Bourke, Wm. H., M.D. ... 8, Moreton Gardens, S.W.
1893 Bourns, N. Whitelaw, M.D.... 78, Redcliffe Gardens, South Kensington, S.W.
1888 Boyton, E. T. A. ... 46, Sebert Road, Forest Gate, E.
1888 Braga, J. F. ... 1, Albert Villas, High Road, Chiswick.
1893 Bridgeford, Walter, A. S. ... 32, Perham Road, West Kensington, W.
1893 Brinton, R. D., M.D. ... 8, Queen's Gate Terrace, S.W.
1896 Bromet, E., M.B. ... St. John's Road, Earlswood, Surrey.
1896 Browne, E. ... 5, Cavendish Mansions, Langham Street, W.
1890 Bruce, Robt. Marston ... Western Hospital, Fulham, S.W.
1889 Bruce, S. Noble ... 43, Kensington Gardens Square, W.
1895 Buckland, F. O., M.D. ... 10, Egerton Place, S.W.
1894 Bucknill, C. C. R. ... Rawtenstall, Manchester.
1896 Burrell, A. W., M.D. ... 165, The Grove, Hammersmith, W.
O.M. Burt, Alfred ... 97, Uxbridge Road, W.
1897 Butler, C. ... 53, Devonshire Street, Portland Place, W.
1897 Buttar, J., M.D. ... 2, Princes Square, Bayswater, W.
O.M. Buxton, A. St. C. ... 44, Devonshire Street, W.

1896 Campbell, H., M.D. ... 20, Devonshire Street, W.
1892 Carre-Smith, H. L. ... 3, Turnham Green Terrace, W.

1896 Cathcart, G. C., M.B. ... 35, Harley Street, W.
1883 Causton, W. H., M.D. ... 365, King Street, Hammersmith, W.
1896 Chaldecott, J. H. ... Madge Hill, Hanwell, W.
O.M. Chapman, C.W., M.D. (C., V.P.) 21, Weymouth Street, W.
1892 Chambers, H. W. ... 165, Goldhawk Road, W.
1892 Cheatle, G. Lenthal ... 117, Harley Street, W.
1896 Chittenden, T. H., M.D. ... 32, Ovington Square, S.W.
1894 Clark, E., M.D. ... 4, Chandos Street, Cavendish Square, W.
1884 Clark, T. Marston ... Twickenham, Middlesex.
O.M. Clarke, W. Bruce, M.B. (P., C., V.P.) ... 51, Harley Street, W.
1888 Clemow, Arthur H. W., M.D. (C., S., V.P., L.) 101, Earl's Court Road.
O.M. Clippingdale, S. D., M.D. (V.P., C., E., P.S.) ... 36, Holland Park Avenue, W.
1897 Coates, G., M.D. ... 30, Brechin Place, S.W.
1889 Coker, O. C. ... 149, Uxbridge Road, W.
1883 Collier, M. P. M., M.S. ... 133, Harley Street, W.
1896 Collier, N. C. ... 10, West Kensington Gardens, W.
1890 Colman, W. S., M.D. (C.) ... 22, Wimpole Street, W.
O.M. Cooper, Alfred (T.) ... 9, Henrietta Street, Cavendish Square, W.
1888 Cooper, Geo. White, M.B. ... 5, Courtfield Road, Gloucester Road, S.W.
1895 Corbould, V. A. L., M.D. ... 43, Victoria Road, Kensington, W.
1897 Cosens, C. ... 49, Oxford Terrace, Hyde Park, W.
1896 Cotterell, E. C. ... 5, West Halkin Street, S.W.
1885 Cottle, Wyndham, M.D. ... 39, Hertford Street, Mayfair, W.
1888 Coutts, J. A., M.B. (C.) .... 54, Upper Berkeley Street, W.
1893 Cox, A. E. ... Duffield House, Upton Road, Watford, Herts.
O.M. Creed, C. P. ... 31, Girdler's Road, West Kensington Park, W.
1897 Crighton, G., M.D. ... 96, Earl's Court Road, S.W.
1885 Crombie, J., M.B. (C.) ... Sidcup, Kent.
1895 Crookshank, F. G. ... 4, Leysfield Road, Shepherd's Bush, W.
1897 Cutler, L. ... 8, Gloucester Road, W.

1897 Dalton, Norman, M.D. ... 4, Mansfield Street, W.
1884 Daniell, Hugo ... 53, Notting Hill Square, W.
1897 Davis, H., M.B. ... 7, Pembridge Crescent, W.
1896 De Castro, G. ... 19, Little Grosvenor Street, Berkeley Sq., W.
1895 Denne, F. V. ... 5, Sterndale Road, W.
1886 Des Vœux, H., M.D. (C.) ... 4, Ashley Gardens, Victoria Street, S.W.
1883 Dickinson, T. V., M.D. ... 33, Sloane Street, S.W.
1887 Dickinson, W. G. ... Elm Bank, West Hill, Putney, S.W.
1895 Dickman, H. G., M.B. ... 4, Turnham Green Terrace, Chiswick.
1897 Dickson, E., M.D. ... 27, Scarsdale Villas, W.
1896 Dickson, W. P. ... Combe Park, Weston, Bath.
1886 Diplock, L. B. ... Ashwood, Heathfield Terrace, Chiswick.
1896 Dobson, L., M.D. ... 59, Addison Gardens, West Kensington, W.
1892 Dockrell, Morgan, M.D. ... 9, Cavendish Square, W.
1887 Dodd, H. W. ... 136, Harley Street, W.
O.M. Dodsworth, F. C. (C.) ... Arlington Park, Gunnersbury, W.
O.M. Doran, Alban (C.) ... 9, Granville Place, W.
O.M. Drewitt, F. G. D., M.D. ... 2, Manchester Square, W.
1886 Dudfield, Reginald, M.D. ... 19, Bloomfield Road, Maida Vale, W.
1887 Dudfield, T. Orme, M.D. ... 14, Ashburn Place, Cromwell Road, S.W.
1884 Dunn, H. Percy (V.P., S., C., E.P., E.J.) ... 54, Wimpole Street, W.
1897 Dunn, J. C., M.D. ... West London Hospital, W.

1883 Eccles, A. S., M.B. (V.P., S., C., E.P., P.) ... 23, Hertford Street, W.

1896 Eccles, G. Tolcher, M.B. ... 63, Sackville Road, Hove.
1896 Eccles, H. Annesley, M.D.... Greystoke, Upper Norwood, S.E.
1890 Eccles, Wm. McAdam, M.S. (C.S.) 124, Harley Street, W.
1893 Eddowes, Alfred, M.D. ... 25, Old Burlington Street, W.
1896 Eden, T. W., M.D. ... 6, Manchester Square, W.
O.M. Edwards, F. Swinford (C., V.P., P.) ... 55, Harley Street, W.
1897 Ellacombe, G. W. ... Bitton Vicarage, near Bristol.
1893 Elliot, Andrew, M.D. (C.) ... 6, Manchester Square, W.
1896 Elliott, H. F. ... Sidney House, Sutton Court Road, Chiswick.
1896 Elliott, H. Scott ... Queen's House, Victoria Road North, Southsea.
1895 English, T. J., M.D. ... 128, Fulham Road, S.W.
1888 Ensor, Edwin Thos., M.D.... 162, Ladbroke Grove, W.

O.M. Fenton, F. E. ... Langstone, Ealing, W.
1897 Féré, E. N., M.D. ... 12, Northampton Square, E.C.
1897 Ferguson, G., M.B. ... 62, Holmdale Road, West Hampstead.
1893 Fincham, W. S. ... 53, Kew Bridge Road, Brentford.
1897 Flavelle, J. ... 3A, Hyde Park Mansions, W.
1896 Forbes-Ross, F. W., M.D.... 63, Chepstow Place, Bayswater, W.
1897 Ford, F. C., M.B. ... 47, Ladbroke Square, W.
1888 Fountain, Ed. Osborne, M.D. 1, Arlington Place, Gunnersbury, W.
1886 Fox, Colcott, M.B. ... 14, Harley Street, W.
1896 Freyer, P. J., M.D. ... 46, Harley Street, W.
O.M. Friend, H. E. ... 1, St. Stephen's Crescent, Westbourne Park, W.

1897 Galloway, James, M.D. ... 54, Harley Street, W.
1887 Gardner, W. T., M.B. (C.)... 11, Branksome Terrace, Bournemouth West.
1884 Gillingham, A. ... 485, High Road, Chiswick, W.
1886 Gloster, J., M.B. ... 15, Upper Phillimore Place, Kensington, W.
1890 Goldney, A. G. N. ... 18, Brook Green, W.
1886 Goldney, A. C. N. ... 18, Brook Green, Hammersmith, W.
1888 Goodsall, D. H. ... 17, Devonshire Place, W.
1891 Goodwin, C. F. ... 93, Richmond Road, Kingston-on-Thames.
1893 Gossage, A. M., M.B. ... 54, Upper Berkeley Street, W.
1894 Gowan, B. C. ... Ravendene, Great Stanmore, Middlesex.
1895 Gray, A. C. E., M.B. ... 1, Elm Park Gardens, S.W.
1894 Graydon, A. ... 124, Cornwall Road, Notting Hill, W.
1896 Gregory, E. T. ... 168, Fulham Road, S.W.
1894 Griffin, N. W. W., M.B. ... 15, Regency Square, Brighton.
1896 Griffith, A. L., M.D. ... 606, Harrow Road, W.
1888 Griffiths, H. J., M.D. ... 5, Kensington Square, W.

1896 Halley, W. ... Park House, Fulham Road, S.W.
1889 Handfield-Jones, M., M.D.... 35, Cavendish Square, W.
1895 Handfield-Jones, R. H. ... 103, Earl's Court Road.
1885 Harper, Jas., M.D. (C.) ... 25, Rosary Gardens, South Kensington, S.W.
1896 Harper, Gerald, M.B. ... 40, Curzon Street, W.
1887 Harris, Carpenter ... 112, Harley Street, W.
O.M. Harrison, H. F. E. ... 33, Shepherd's Bush Green, W.
1890 Harrison, Reginald ... 6, Lower Berkeley Street, W.
1896 Harrison, C. J., M.B. ... 36, Cheyne Court, S.W.
1896 Hartley, R., M.D. ... 112, Westbourne Grove, W.
1887 Hartzhorne, B. F. ... Blenheim Lodge, High Road, Chiswick, W.
1896 Harvey, J. S., M.D. ... 1, Astwood Road, Cromwell Road, S.W.
1888 Heddy, W. J. ... 46, Redcliffe Gardens, S.W.
1890 Hill, W., M.D. ... 28, Weymouth Street, W.
1897 Hills, W. J. D. ... 17, Redcliffe Gardens, S.W.
1888 Hill-Wilson, Arthur E. ... 217, Goldhawk Road, W.

O.M.	Hogan, J. C., M.D. ...	3, Redcliffe Gardens, South Kensington, S.W.
O.M.	Hood, D.W.C., M.D. (P., V.P.)	43, Green Street, W.
1896	Hogg, S. ...	102, Palace Gardens Terrace, Kensington, W.
1896	Horne, W. J., M.B. ...	17, Bartlett's Buildings, E.C.
O.M.	Hubbard, H. W. ...	19, Elgin Crescent, Notting Hill, W.
1894	Hughes, E. A. ...	10, Old Cavendish Street, W.
1885	Humphreys, F. W. ...	24, Sinclair Gardens, West Kensington Park, W.
1893	Hunter, William, M.D. (C.) ...	103, Harley Street, W.
1887	Hurlbutt, S. ...	15, Old Burlington Street, W.
1896	Hyde, S., M.D. ...	Lismore House, Buxton.
1896	Ince, G. ...	Kensington Dispensary, Church Street, W.
1891	Jackson, Charles J. ...	Town Hall, Fulham, W.
1896	Jackson, Surg.-Capt., M.D. ...	Wellington Barracks, S.W.
1895	James, J. B. ...	93, Bridge Road, Hammersmith, W.
O.M.	James, W. Culver, M.D. ...	11, Marloes Road, Kensington, W.
1893	Jessett, F. Bowreman ...	1, Buckingham Palace Mansions, S.W.
1896	Jessop, W. H., M.B. ...	73, Harley Street, W.
1891	John, William ...	19, Avonmore Road, W.
1894	Johnston, George F., M.D. ...	6, Manchester Square, W.
1892	Johnston, J. W., M.D. ...	The Leys, Fordingbridge, Hants.
1887	Jones, Macnaughton, M.D. ...	141, Harley Street, W.
1886	Juler, H. E. ...	23, Cavendish Square, W.
1861	Keen, William, M.D. ...	Argyle House, King's Road, Chelsea.
1896	Keep, A. C., M.D. ...	7, Lower Seymour Street, W.
O.M.	Keetley, C. B. (P., V.P., S., C., E.P., L.) ...	56, Grosvenor Street, W.
1891	Kenwood, H. R., M.B. ...	9, Alexander Villas, Finsbury Park, N.
1884	Kiallmark, H. W. ...	5, Pembridge Gardens, W.
1897	Kirby, W., M.D. ...	Hilden, Sutton Court Road, Chiswick.
1896	Kloster, O., M.D. ...	Glynderwen, Newport, Monmouth.
1896	Knight, H. ...	Morholme, Woking.
1893	Krohn, Ronald G. S., M.D. ...	81, Queen's Crescent, Haverstock Hill, N.W.
1887	Lake, Richard (C., S., V.P., E.P.)	19, Harley Street, W.
O.M.	Lamb, W. H., M.B. (C., V P.)	23, Palace Court, W.
1894	Lancaster, H. F., M.D. ...	154, Westbourne Terrace, W.
1896	Lang, E. J. ...	3, Maddox Street, W.
O.M.	Lawrance, F. (P., V.P., C., T.)	360, King Street, Hammersmith, W.
1884	Leeson, Oliver J. ...	Collingham House, Cromwell Road, S.W.
1893	Lewis, Ernest Wool ...	12, King Street, Hammersmith, W.
1896	Ley, G. ...	4, Longfield Road, Ealing, W.
O.M.	Lloyd, R. W. (V.P., S., C., E.P.)	27, Russell Road, Kensington, W.
1892	Lloyd, F. G. ...	27, Russell Road, Kensington, W.
1896	Lockyer, H. J. C. ...	Kensington Dispensary, W.
1892	Loftus, A. S. ...	Lindisfarne, Christchurch Road, Boscombe.
1883	Longhurst, A. K. ...	Hillingdon, Mount Park Road, Ealing, W.
1896	Low, F. H., M.B. (C.) ...	12, Sinclair Gardens, W. Kensington.
1895	Low, Harold, M.B. ...	10, Evelyn Gardens, S. Kensington.
1882	Low, R. Marsden, M.B. (C.)	70, Philbeach Gardens, S.W.
1894	Lubbock, E. A. ...	632, Fulham Road, S.W.
O.M.	Lunn, J. R. (C.) ...	St. Marylebone Infirmary, Notting Hill, W.
1888	Lush, Percy J. F., M.B. (A.) ...	4, Maresfield Gardens, Hampstead, N.W.
1896	Lyle, F. W., M.D. ...	39, The Avenue, Castle Hill, Ealing, W.
1886	Lynch, J. Roche ...	74, Holland Park Avenue, W.
1890	Lynes, John ...	6, Argyll Road, Kensington, W.
1896	Lyth, E. R., M.B. ...	117, Goldhawk Road, W.

O.M.	Mackinlay, J. G. ...	15, Stratford Place, W.
1896	Macfarlane, Aymler, A. ...	1, Montpelier Terrace, Brighton.
1890	MacLaren, J. A., M.B. ...	2, Fairholme Road, W. Kensington
1897	Macleod, W. A., M.B. ...	9, Pembridge Villas, Bayswater, W.
1893	Maidlow, W. H., M.D. ...	14, Park Hill Rise, Croydon.
1896	Maggs, O. H. A. ...	165, Buckingham Palace Road, S.W.
1896	Malcolm, J. D., M.B. ...	13, Portman Street, W.
O.M.	Mallam, W. P. (C.) ...	169, Uxbridge Road, W.
1891	Mallard, F. R. (A.) ...	23, Bridge Road, Hammersmith, W.
1890	Mansbridge, J. (C.) ...	112, Harley Street, W.
1890	Margrave, M. L. ...	3, Devonia, Newton Abbott, Devon.
1885	Mark, Leonard (V.P., S., E.P., C., A.) ...	61, Cambridge Street, Hyde Park, W.
1896	Marks, W. J. H. ...	7, Hertford Street, Mayfair, W.
1883	Marsh, Howard ...	30, Bruton Street, W.
1894	Martin, J. W., M.D. ...	Burnfoot, Clondin, Dumfries, N.B.
1884	Mason, J. W. ...	1, Osnaburgh Terrace, Regent's Park, W.
1884	Mason, J. W. B., M.D. ...	1, Osnaburgh Terrace, Regent's Park, W.
1885	Masters, J. A., M.D. (C., V.P.)	57, Lexham Gardens, Kensington, S.W.
1893	May, C. Gould, M.D. ...	26, Walton Street, Pont Street, S.W.
1894	McCann, Frederick J., M.D. (S.)	5, Curzon Street, W.
1897	McDougal, E. ...	Portmore Cottage, Portmore Park, Weybridge.
1897	Mc Namara, J., M.B. ...	73, Milson Road, West Kensington W.
1887	Mennell, Zebulon ...	1, Royal Crescent, Notting Hill, W.
1894	Menzies, Henry, M.B. ...	St. George's Hospital, S.W.
1895	Menzies, J. Herbert (V.P., S., C., E.P.) ...	47, Earl's Court Square, S.W.
1896	Miles, W. E. ...	St. Bartholomew's Hospital, E.C.
1895	Miller, F. R., M.D. ...	31, Shepherd's Bush Road, W.
O.M.	Miller, J. D., M.B. ...	152, Holland Park Avenue, W.
1893	Mills, H. H. ...	21, St. Mary Abbott's Terrace, Kensington, W.
1888	Moore, Stephen H. ...	75, Sydney Street, Chelsea, S.W.
1896	Morison, A., M.D. ...	14, Upper Berkeley Street, W.
1896	Morison, H. B., M.B. ...	18, Holland Park Avenue, W.
1893	Morris, E. H. Grant, M.B....	8, Gloucester Terrace, Onslow Gardens, S.W.
1896	Mortimer, J. D., M.B. ...	22, Cheyne Gardens, Chelsea, S.W.
1896	Mossman, F. V. ...	317, Waterloo Road, Manchester.
1896	Moullin, J. A. Mansell, M.D.	69, Wimpole Street, W.
1896	Muggleton, F. C., M.D. ...	Mount View, Anerley Hill, Norwood.
1883	Muir, J. C. P. ...	94, Ladbroke Grove, Notting Hill, W.
1896	Murray, C. Stormont ...	85, Gloucester Place, W.
1891	Murrell, G. F. ...	Eden Cottage, Craven Road, Reading.
1896	Musson, William C. ...	61, Bridge Avenue, Hammersmith.
1896	Myddelton-Gavey, E. H. ...	124, Harley Street,
1894	Naumann, J. C. F., M.D. ...	125, Gower Street, W.C.
1896	Nicoll, J. V. ...	147, Cromwell Road, S.W.
1887	Noott, W. M. ...	8, Kensington Park Road, W.
1896	Norman, F., M.D. ...	5, Holland Road, Brixton, S.W.
1896	Oakley, H. C. ...	30, Sinclair Road, West Kensington, W.
1887	Orr, A. Aylmer, M.B. ...	204, Earl's Court Road, S.W.
1895	Orr, J. J., M.D. ...	493, King's Road, Chelsea, S.W.
1882	Orton, G. H., M.D. ...	1a, Campden Hill Road, Kensington, W.
1894	Otway, A. Caroll ...	Exeter House, Barnes.
1887	Owen, Edmund ...	64, Great Cumberland Place.
1882	Owles, J. A., M.D. (V.P., C.)	Hill View, Woking, Surrey.
1888	Paget, Stephen (C.) ...	70, Harley Street, W.

O.M.	Palmer, F. S., M.D. ...	Compton Lodge, East Sheen, S.W.
1891	Palmer, Foster J. ...	8, Royal Avenue, Chelsea.
1896	Pardoe, J. G., M.B. ...	3, Selborne Place, Littlehampton.
1894	Parker, Charles A. ...	Colne Valley, Rickmansworth.
1890	Parker, W. Turnour ...	68, Lillie Road, Fulham.
1894	Parsloe, H. H. ...	Davona House, Ivydale Road, Nunhead, S.E.
1887	Paramore, R., M.D. ...	2, Gordon Square, W.C.
1892	Part, J. Shepley ...	20, Ashchurch Park Villas, Shepherd's Bush, W.
1882	Patmore, Tennyson ...	H.M. Prison, Wormwood Scrubbs, W.
1896	Paton, E. P., M.S. ...	84, Park Street, W.
1889	Pattison, E. S. ...	Granville House, Fulham Road, S.W.
1886	Pearson, D. Ritchie, M.D. ...	23, Upper Phillimore Place, Kensington, W.
1894	Pegler, Louis H., M.D. ...	25, Old Burlington Street, W.
1897	Philps, F. G. ...	76, Redcliffe Gardens, S.W.
O.M.	Pickett, J., M.D. (V.P., C.) ...	26, Colville Square, W.
1894	Pillow, H., M.D. ...	1, Pembridge Gardens, W.
1883	Pocock, F. E., M.D. ...	The Limes, St. Mark's Road, Notting Hill, W.
1896	Pollock, J. D., M.D. ...	98, Earl's Court Road, S.W.
O.M.	Pope, H. Campbell, M.D. (V.P., S., E.P., P., C.) ...	280, Goldhawk Road, Shepherd's Bush, W.
1897	Porter, R. J. ...	61, St. Dunstan's Road, W.
1896	Potter, E. F., M.D. ...	64, Welbeck Street, W.
O.M.	Potter, H. Percy, M.D. (C., V.P., P.) ...	Kensington Infirmary, W.
1894	Pratt, W. Sutton, M.D. ...	Penrhos, Rugby.
1896	Pritchard, O., M.D. ...	37, Southwick Street, Hyde Park, W.
1896	Propert, W. A. ...	112, Gloucester Place, W.
1897	Ramsay, H. M. ...	35a, Hertford Street, Mayfair, W.
1883	Reece, R. J., M.D. ...	31, Holland Villas Road, W.
1883	Reid, John, M.D. ...	31, Bridge Avenue, Hammersmith, W.
1891	Revill, G. L. H. ...	Heighington, Lincoln.
O.M.	Richardson, Gilbert, M.D. ...	Hillside, Putney Hill, S.W.
1887	Roberts, John D. ...	103, Uxbridge Road, Ealing, W.
1890	Robinson, G. H. D., M.D. (C.)	84, Park Street, Grosvenor Square, W.
O.M.	Rogers, Hildyard ...	43, Uxbridge Road, W.
1896	Rooke, E. M. ...	88, Cromwell Road, S.W.
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1893	Routh, Amand J. M., M.D. ...	14a, Manchester Square, W.
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1895	Scharlieb, H. J., M.B. ...	149, Harley Street, W.
1895	Schofield, S. R., M.B ...	Queen's Club Gardens, West Kensington, W.
1889	Scott, A., M.D. ...	Bradford Street, Bocking, Essex.
1894	Scott, A. L. ...	Westbourne Villa, Uxbridge Road, Ealing, W.
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1890 Stocker, E. G. ... Weedon, Northamptonshire.
1896 Stoker, George ... 14, Hertford Street, Mayfair, W.
1867 Sturge, H. H. ... 81, Elgin Avenue, W.
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1896 Sutherland, G., M.D. ... 9, Old Cavendish Street, W.
1889 Sutherland, H., M.D. (C., V.P). 21, New Cavendish Street, W.
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1893 Thompson, Maitland ... Brooklands, Hemel Hempstead, Herts.
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(P., V.P., C.)
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1888	Webb, H., M.D.	...	Wentworth House, Parson's Green, S.W.
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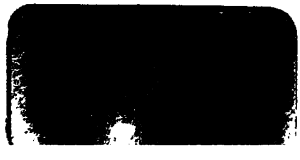

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